

Canadian Public Health Journal

Devoted to the Practice of
PREVENTIVE MEDICINE

The State Health Insurance Movement in
British Columbia

J. W. McINTOSH

Public Health Services in Alberta

M. R. BOW

Forms of Health and Sickness Insurance in
Saskatchewan

F. C. MIDDLETON

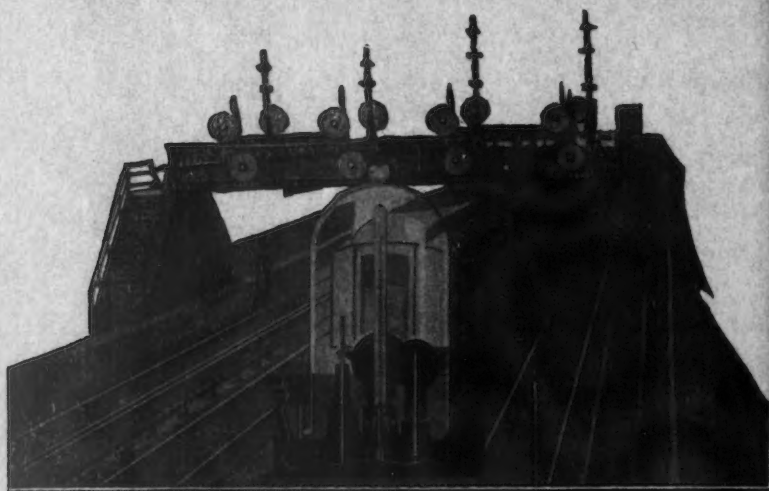
Public Medical Services in Manitoba

F. W. JACKSON

League of Nations---Sixteenth Session of the
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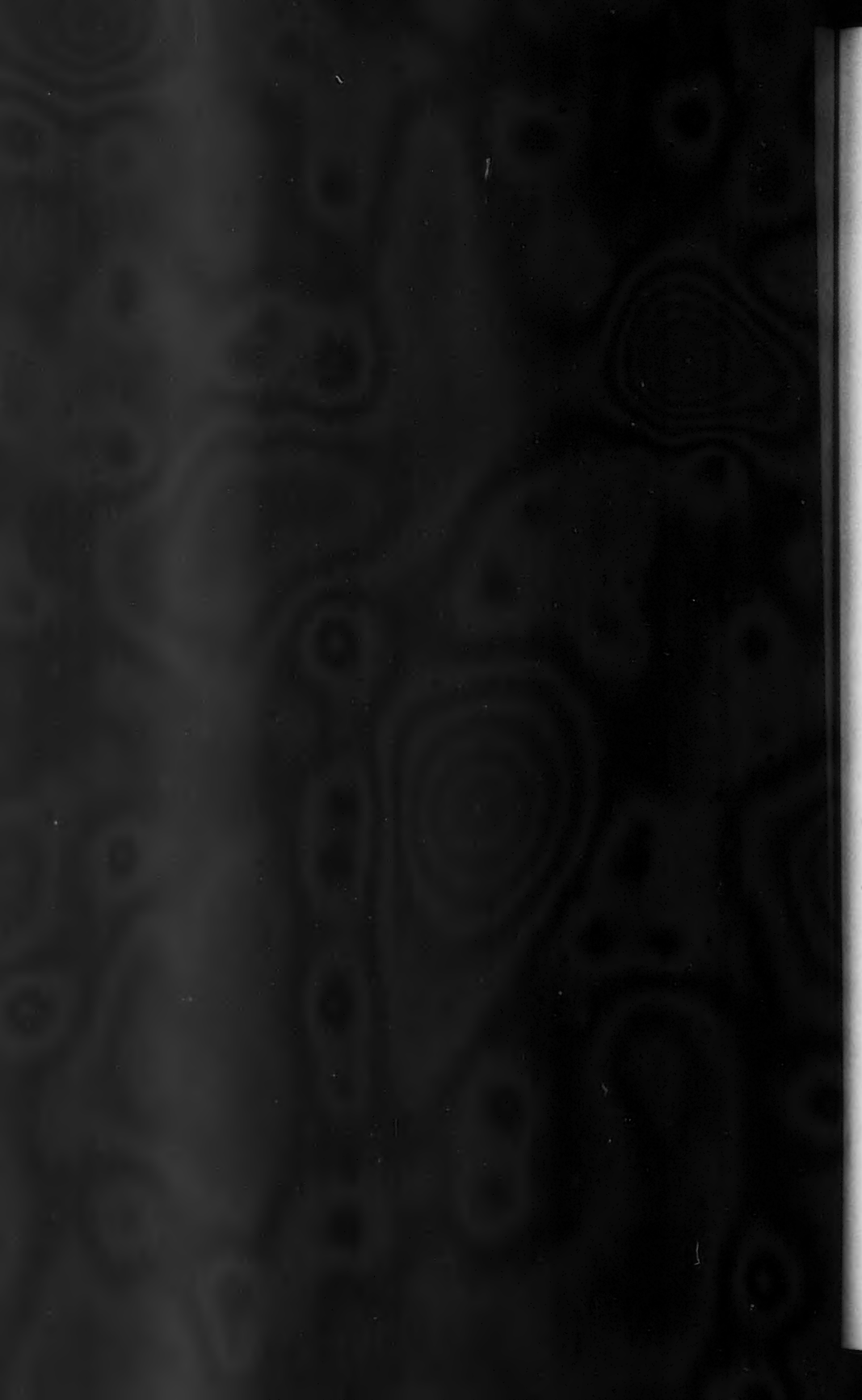
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Foreword

NATIONAL HEALTH INSURANCE

"How, then, may the problem be solved of placing competent medical skill within reach of all our citizens, on a basis that will ensure them every care, be just to the members of our profession, and satisfy the legitimate demands of the nurse and the hospital? In my judgment, there is only one possible solution—voluntary health insurance, instituted, organized, and controlled by the medical profession, and widely applied."

IN these words Dr. W. Harvey Smith, President of the Canadian and British Medical Association, in his inaugural address focused the attention of the medical profession of Canada on the subject of national health insurance. In the course of his excellent address, he traced briefly the developments in public health work and in social medicine in three of our western provinces. The Editorial Committee, therefore, feel that a more detailed presentation of these developments would be opportune.

In a later issue of the JOURNAL there will appear an authoritative presentation of the national health insurance scheme of Great Britain, contributed by Mr. R. W. Harris of London, England, whose volume on Medical Insurance Practice is so well known.

The State Health Insurance Movement in British Columbia

J. W. McINTOSH, B.A., M.B., D.P.H.,

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FOLLOWING the war the Soldiers' Party Leader in the Legislature, during the Session of 1920, introduced a resolution favouring the principle of compulsory state health insurance, and urged its adoption in British Columbia. A member of the Government made an amendment authorizing the appointment of a Royal Commission to study the question of state health insurance and to report on the advisability of introducing it in the Province. The Legislature agreed; the Government subsequently appointed the Royal Commission, with E. H. S. Winn, Esq., Chairman of the Workmen's Compensation Board as its Chairman. The Royal Commission held sittings in various parts of the Province during 1920, and reported favourably. A return of the report was never made, though asked for repeatedly in the House.

Some years later, under pressure of the Labour members, the same minister introduced an amendment to their resolution, favouring the principle but switching the responsibility to the Federal Government.

On March 14th, 1928, a resolution was passed authorizing the appointment of a committee of five members to enquire and report. That summer the Government was defeated at the polls. After the present Government came into power, on February 1st, 1929, a resolution to reaffirm the action of the preceding Legislature was carried unanimously, after amendment by the Labour-Conservative member for Burnaby, calling for a Royal Commission of members of the House to study and report on the question of State Health Insurance and Maternity Benefits. On April 16th the following members of the Legislature were appointed for this purpose, C. F. Davie, Esq., Chairman, W. F. Kennedy, Esq., G. S. Pearson, Esq., and Doctors L. E. Borden and J. J. Gillis.

During the summer of 1929, sittings were held throughout the Province, and on February 11th, 1930, a progress report was presented to the Legislature. Copies of this report are available. The report was received and the Commission was authorized to continue. Further sittings have been held during the present summer and fall, concerning which, and the interim report, comment is made later. The Commission is expected to bring in a final report at the next Session, early in 1931.

The Attitude Towards State Health Insurance, in 1920.

The Legislature. The question in 1920 having been brought forward

and pressed by the ex-soldier members in the House, it was felt, as subsequent events proved, that while neither the Government nor Opposition wished to antagonize its advocates, they were prepared only to defer action by appointing a Royal Commission.

The Public. The Commission found labour and ex-soldier organizations to be strong advocates, but the general public more or less disinterested and uninformed. The employers of labour were found, unexpectedly, to be more or less favourable. Strong opposition was presented by the medical profession, who, however, afterwards appointed a committee to study state health insurance, feeling that sooner or later it would come in some form or other, and in anticipation of such an outcome, they would hold a watching and studious brief, so that they might not be taken unexpectedly; they would thus be in a more advantageous position than the profession had been in 1911, in Great Britain, on the introduction there of the health insurance measure.

The Influence of the Union of Municipalities.

The resumption of active interest was largely due to action taken by the municipal representatives in convention assembled. By resolution adopted, the principle was endorsed and action requested. A questionnaire was sent to every municipal council in the Province calling for consideration of a state health insurance measure; if the council was favourable to such a scheme they were asked to bring pressure to bear upon the Legislature.

In British Columbia the Municipal Act throws on the individual municipality the onus of looking after its own indigent citizens. This, together with the ever growing requirements for hospitalization, has been largely instrumental in urging the various councils to seek ways and means of handling the problem more scientifically, so as to lessen this burden upon the taxpayer by its more equitable placement.

THE PRESENT SITUATION

The 1930 Progress Report of the Royal Commission

This report comprises 24 pages compiled from a 720 page volume of the Commission's investigations of this question at home and abroad. The Commission notes that the Federal Government places the onus on the provinces to initiate such measures, while acknowledging a moral obligation by making parliamentary grants in aid. In this attitude the late and present prime ministers are reported to have acquiesced.

Adapting the calculation methods of Homer Folk of New York, to British Columbia, the total annual loss due to sickness would amount to over \$78,000,000, to combat which an expenditure is made from all sources, federal, provincial and municipal, for public health measures,

of approximately \$4 for every \$1000 of loss, *i.e.*, about 0.4 per cent. The Report states, in part,

"The desirability of testing British Columbia's opinion as to the present necessity of instituting State Health Insurance in and for the Province . . . was recognized. . . . Sufficient data are available to establish the fact that private insurance with commercial companies against sickness losses is carried by only a minor fraction of the wage-earning and low-income community. Membership in fraternal societies including relief during illness among their benefits, also is confined to a small minority. . . . Such conditions of membership are prescribed that an even smaller part are eligible therefor. At the same time the financial ability of a number of such societies to provide their guaranteed benefits under present scale assessments is questionable, should abnormal demands be made upon their funds through epidemic or other exceptional pressure."

The Report states that a plan is quite feasible by which fraternal societies might continue to function as insurer agents of the State, with Government supervision and guarantee of their solvency.

Replies to the questionnaire represent approximately 65 per cent of an estimated total of 100,000 wage earners in the Province. There was virtually a 100 per cent response to the questionnaire as to voluntary policies from 350 major British Columbia industries. About 40 per cent have some form of welfare organization. The costs run from 0.33 per cent to 3.5 per cent of the pay-roll, some paid entirely by employers, some entirely by the employees, but generally by both. In 28 there were included medical services to the family also. The cost to workers varied from \$1.00 to \$4.30 per month per man, with from 50 to 75 per cent more cost to married men. Many valuable statistical data are provided as to the different industries. Summing up, about 94 per cent were favourable to the principle of state health insurance for British Columbia for the following reasons: (a) the natural tendency to want to improve the health standard, (b) the likelihood of reducing costs. Of these in favour of health insurance the majority preferred a compulsory system.

On page 26 of the Report, the following six considerations are set out as advantages to employers, claimed in a state insurance system, offsetting any increase of overhead expenses resulting from it.

(i) A wider spread of insurance by its general application on actuarial principles will presumably reduce the average cost to below that now possible under existing voluntary employees' benefit association schemes.

(ii) Administrative costs of such services will be eliminated.

(iii) Equities now missing in the operations of competing interests will be assured, to the marked advantage of employer bodies taking active interest in the welfare of their workers.

(iv) All employers will gain by decreased interruption of the sus-

tained capacity effort of their working forces, through betterment of health standards, anticipation and prevention of the development of illness, enhanced general efficiency, relief of the worker from worry, and the extension of the span of active life for experienced employees.

(v) The reduction of abnormal charges, now carried by the Province and by municipalities in connection with health protection and care of the sick, aid for hospitals, and physicians' retainers, through a considerable proportion of such charges being assumed by established insurance funds, will in turn be reflected in reduced taxation in such behalf now borne by industry and otherwise.

(vi) A major part of the sickness-costs burden now placed upon the Province and municipalities through non-payment of hospital charges by the individual will be relieved when such costs are provided from the general resources of the health insurance scheme.

To Whom Should Insurance Apply?

In discussing the inclusion of the insured *employee's family* in the benefits secured by the insurance system, the fact is gleaned from the last Dominion census report, that the average family, exclusive of the employee himself, is only 1.43 for British Columbia (the smallest in Canada), as compared with 3.34 in those European countries in which the system is in force. The inference may be drawn from this that British Columbia would be in the more favourable position from the cost point of view in considering the inclusion of the whole family.

Compulsory insurance has been extended to *agricultural workers* in seven European countries, in five of these during the past few years. Difficulties in the administration of benefits exist but are being overcome, and the situation in this regard is rapidly improving. The movement is being extended also to include such occupational groups as *domestic servants* and *home workers*, whose employment status is more difficult to define.

The percentage covered by compulsory insurance varies in different countries ranging from 5 per cent to 47 per cent of the total population, and from 21 per cent to 92 per cent of the employed population.

As a summary, the Royal Commission in its interim report states:

"Our investigations thus far convince us that there is justification and a general demand for the introduction in British Columbia of an economically sound and equitable public health insurance plan, in the interests of the majority of provincial workers, of provincial industries, and of the state in the more effectual safeguarding and preservation of communal health, the more rational distribution of sickness costs, and the scientific reduction of such charges to the Government, to employers, and to individual citizens."

Progress of the Royal Commission in 1930.

Increased interest has been manifested. Strong representations have been made on behalf of the small farmer being included in any

system that may be adopted, and the Commission appears sympathetic to the proposal. Public hospitals have claimed that their persistent deficits are due to the large number of non-pay patients, and urge that a state system of insurance be instituted with provision for hospital care. A strong plea has been made to include all employees irrespective of the amount of their respective earnings.

The attitude of the medical profession was officially presented by the British Columbia Medical Association. The profession sees the need, realizes that state insurance is inevitable, and maintains a watching brief to protect its interests. The following is quoted from the statement presented to the Commission by the Association and reveals the attitude of the physicians in British Columbia:

"It has been realized that there is a demand, chiefly on the part of the wage earning class and the men of moderate means, for the inauguration of some scheme whereby the cost of illness may be more evenly distributed. The cost of medical care in its fullest modern form is an excessive burden to the working man. . . . These methods of diagnosis and treatment . . . should be available to all. . . . There is no adequate system for prevention of disease. . . . The medical profession would support and endorse any system which would improve the health of the community, lessen disease and prevent illness as far as this can be done. . . . The scope should be complete, including hospital, specialists, nursing, modern methods of diagnosis and treatment of all kinds necessary . . . as an end at which to aim, after a more limited beginning, and should include the family. The schemes should include an adequate system of preventive medicine under full-time workers, doctors and nurses, whose work would not include therapeutics and diagnosis. . . . The doctor should be paid for the work done on the basis of a fee list. . . . There should be free choice of physician. The scheme should be administered under a Board, and lodges, benevolent societies, etc., should be absolutely barred as carriers under the Act. . . ."

The attitude of the Press is revealed by an editorial in the *Vancouver Province* of February 10th, 1930, on the "Interim Report of the Royal Commission," which states that "it indicates that there is widespread interest in the scheme, and pretty general approval" and proceeds to show that, of the interests consulted, the majority were favourable; that of the municipal corporations replying to the Commission's questionnaire, not one registered opposition. It states further that the scheme, "also includes or can be made to include, the provision of facilities for examination, advice and treatment which will have the effect of reducing sickness. This is an important part of the plan, and should have a wide public appeal.

"No province in Canada has yet adopted a health insurance scheme, nor has any American state. This fact, however, need not deter British Columbia if it considers the scheme feasible. This Province has been too often in the van in social legislation to be any longer afraid of leading."

Periodic Medical Examinations and Health Insurance.

This question was greatly stressed before the Commission by the Burnaby Public Welfare Council. From the point of view of public health, the great aim should be to prevent illness. Periodic medical examinations could be made one of the greatest factors in this direction. By making a yearly thorough examination of every insured person, a large percentage of the potential causes of illness could be discovered; the elimination or correction of these would do more to reduce the average number of days of illness, now estimated at seven days, than any other single measure.

In the experience of the Life Insurance Institute, one large company spent \$60,000 in 6 years on policy holders in periodic examinations and had an actual gain of \$120,000 in extra premiums from those whose lives were extended as a result; this is 100 per cent return on its investments. In 9 years there was an actual average reduction of 10 per cent in deaths and 53 per cent in impaired lives in these policy holders submitting to periodic examinations. The Guardian Life showed a 23 per cent reduction in the death rate of its policy holders who underwent periodic re-examination. Professor Ryan of Tufts Medical College found that within one year of the first examination, 69 per cent of the general medical cases, 53 per cent of the eye, ear, nose and throat, and 62 per cent of the surgical cases were cured.

Medical men are stimulated by periodic examinations to pay more attention to the personal hygiene of the individual. It is worthy of note that there was found some physical defect, or faulty mode of living in 99 per cent of those examined by the Life Insurance Institute.

Proper remuneration for these examinations together with a fixed *per capita* fee for regular medical attendance provides the required stimulus to practise preventive medicine. The consequent reduction in the income of the physician from treating disease will be more than offset by,—an adequate recompense for the periodic examination; an extension of medical services to those who at present are without any. (The Rochester N.Y. survey of the Metropolitan Life Insurance Company showed 39 per cent in this class); by bringing into the remunerative class a large percentage of the doctor's clientele which now pays nothing.

PROSPECT

The findings and tenor of the interim report together with the apparently favourable attitude of the Commissioners during the public sittings seem to presage a recommendation for the adoption of a measure of State Health Insurance for the Province.

The final report will be made at the coming Session of the Legislature early in 1931.

Of the attitude of the people's representatives towards the measure one can only speculate, but, to date, it would appear to be unanimously in favour of the principle. If the press indicates the "*vox populi*" it presages action, and, as one journal suggested, the Government might think it a not unsuitable bid for a return verdict on appeal to the country.

Public Health Services in Alberta

M. R. BOW, M.D., D.P.H.

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IN many countries to-day there appears to be general recognition of the need for the development of a system that will insure efficient medical and hospital service for all the people. Under present conditions the prompt and skilled care which the medical profession and the hospitals are organized to render is not accessible to a very considerable proportion of our people. This is a question that is receiving careful study and investigation by leaders of thought not only in the medical and allied professions, but which is even more significant, by the layman, who has come to recognize that health is the right of every citizen and not the privilege of those who can afford to pay for it or who must accept it as a form of charity. One has only to refer to the most widely read magazines and newspapers to realize the great interest of the people in health questions and the widespread demand for health information. The educational campaigns of public health departments, of the medical and allied professions, of the great welfare and philanthropic organizations, of the great insurance companies and other such organizations are beginning to bear fruit in a public demand that those services which are essential to the maintenance of health be accessible to all.

It will perhaps be of some interest in connection with the study of this problem of health insurance to give a brief outline of some of the forms of health service which have been developed in the Province of Alberta in recent years. Inasmuch as these activities are financed by taxation, they may be considered in a general way as forms of health insurance. When one looks at the question from this point of view it is evident that not only in Alberta but in most of the other Provinces of Canada there has already been a considerable development of activities designed to safeguard the health of the people and maintained out of public funds.

HOSPITALS

Municipal Hospitals

The Government has encouraged an extensive development of municipal hospitals, which are operated under the provisions of the Municipal Hospitals Act. The first municipal hospital was organized in 1918 and there are now twenty-two such hospitals in the Province, providing accommodation for 622 patients. These municipal hospitals serve almost one-half of the rural population and are modern in construction and equipment.

The "municipal hospital district" is established by the Minister of Health on petition of municipal councils or of ten per cent of the rate-payers residing in the territory included in the hospital district. After a scheme for hospital service has been prepared and has been submitted to the Board of Public Utilities Commissioners it is advertised in papers circulating in the hospital district. Arrangements are made by the Provisional Board for public meetings in different sections of the hospital district so that the ratepayers may become fully informed as to the hospital scheme. In due time the scheme is submitted to the vote of the people, a two-thirds majority being required for its approval. If a majority only of those entitled to vote, vote in favour of the scheme the district remains established for a period of one year, within which time a second vote may be taken if the Provisional Board so decides. If the scheme is approved, arrangements for the erection of the hospital proceed, and the necessary funds raised by the issue of debentures which are retired over a term of twenty years. All assessable land in a hospital district contributes towards its support, the average tax per acre over the hospital district being three cents, but the individual tax is based on the assessed value of the land in each municipal district. All hospital ratepayers or supporters, including their families, are entitled to hospital service at the rate of one dollar per day. By supporters is meant certain individuals in rural communities employed on farms or in towns who are not tax-payers, but who by payment of a certain stipulated sum, usually six dollars, may become hospital supporters and entitled to the *per diem* hospital rate (usually one dollar). In the case of owners of single lots in villages, hamlets or towns, the Act provides that their annual tax must be brought up to the amount paid by hospital supporters if they are to be eligible for hospital service at the *per diem* rate of one dollar. On ratification of the hospital scheme the Provisional Board becomes a body corporate and carries on until opportunity is given for the election of a Board at the next municipal elections. This Board is responsible for the operation of the hospital under the provisions of the Municipal Hospitals Act, the Department acting in an advisory capacity.

These hospitals have proven a great boon to the people, making local hospital service available to many sections of the Province which would otherwise be denied it. The danger to be guarded against, and which presents a problem in connection with the work carried on in some hospitals is the tendency to attempt major surgical work which could be done with more safety to the patient in hospitals situated in the larger centres. This is, of course, a problem that is not confined to municipal hospitals. These twenty-two municipal hospitals have rendered splendid service in the twelve years during which they have been in operation. During this period 76,022 patients have been treated. These hospitals have proven very successful financially,

many having financed extensions to buildings and equipment out of their reserve funds as they are permitted to do under the provisions of the Municipal Hospitals Act.

The municipal hospital system in itself constitutes a form of health insurance as was previously stated, hospital ratepayers and supporters contribute their tax and in return they, as well as their families, are entitled to hospital service at the special rate of one dollar per day.

Approved Hospitals

There are eighty-seven "approved hospitals" in the Province, including the municipal hospitals, entitled to the Government grant of fifty cents per patient per day. The amount paid by the Government to the hospitals of the Province by way of grants was \$437,710.00 for the year 1929. The total bed capacity of these eighty-seven hospitals is 3,114.

Sanatoria

The Provincial Sanatorium provides accommodation for 210 patients and is operated by the Provincial Department of Health. Municipalities are held responsible for the maintenance of their residents who are unable to pay for sanatorium treatment. The *per diem* cost for the year 1929 was \$2.93, but the charge for the maintenance of any patient who is the responsibility of a municipality is \$1.50 per day, the balance of the cost being made up by the Government.

A travelling diagnostic service is carried on from the sanatorium, the diagnostician visiting towns, villages and rural districts at stated intervals, in carrying on this work. In addition, the medical staff of the sanatorium provides the service for chest clinics which have been established in the cities of Calgary and Edmonton.

Provincial Special Hospital

Another type of hospital work which is of interest in connection with the question of health and the State, is that of the Provincial Special Hospital which was opened in January, 1928, for the after treatment of patients suffering from poliomyelitis. This hospital provides special facilities for the treatment of sixty patients. It was opened to meet the need for this special service following the outbreak of poliomyelitis in the Province in 1927 and the results achieved have fully justified the expenditures required to provide this service.

The charge for maintenance is \$1.75 per day, which includes hospital and medical care. A teacher is employed to give bedside instruction to the children and dental service is also provided by the Department. Patients are admitted irrespective of their ability to pay for treatment. The medical officer in charge is an orthopaedic surgeon. The after care of these patients constitutes a very serious

problem, particularly in a province such as ours in which sixty per cent of the population are rural and in many cases remote from hospital and medical care. From January, 1928, to March, 1930, two hundred and forty patients have been treated, 154 in the hospital and 86 in the out-patient department.

This institution has met a real need and is, I believe, the first institution in Canada to be built and equipped for this special type of work. Because of the contact this hospital has given the Department with patients convalescing from poliomyelitis it has been possible to meet the urgent demand of physicians for a supply of poliomyelitis convalescent serum for the treatment of new cases of this disease reported in the Province during the current year. This serum has been supplied by the Department free of charge.

On April 1st of this year the administration of this hospital was taken over by the University Hospital, of which it is now a department.

MUNICIPAL PHYSICIANS

At the last Session of the Legislature an Amendment was introduced to the Municipal Districts Act, permitting municipal districts or parts of municipal districts to combine for the purpose of engaging municipal physicians and public health nurses. This Amendment reads as follows:

(2) "Whenever the council desires to pass a by-law for engaging a physician or public health nurse or a clinic, or any of them, to attend residents of a part of the municipal district, either in conjunction with other municipal districts, or separately, it shall proceed as is set out in subsections (2) to (5) inclusive of Section 157 of this Act, save that reference in such subsections to the municipal district shall be taken to refer to the said part of a municipal district.

(3) "If it is desired that two or more municipal districts should join in engaging a physician, or a public health nurse or clinic or any of them, to attend residents in an area consisting in whole or in part, of parts of such municipal districts, the by-law shall set out the total assessment of the property in the part of the municipal district affected.

(4) "In the event of the by-law being lawfully and finally passed, in all the parts of the said area, the municipal districts shall appoint a committee of not less than three persons who shall have power to engage any of the persons aforesaid in accordance with the terms of the by-law and to superintend and otherwise regulate the services given by such physician, public health nurse or clinic.

(5) "In each such municipal district, a special tax sufficient to produce the proper proportionate part of the expenses incurred by the said committee shall be levied upon the property of the proprietary electors who are qualified as such by reason of property situate in, or business carried on in, the part of the municipal district included in the area."

Inasmuch as sixty per cent of the population of Alberta are rural, and physicians tend more and more to gravitate to centres of population, it is becoming increasingly difficult to retain competent physicians in rural districts. A number of municipal councils have made enquiries concerning this legislation and it is expected that agreements will be made by several of these with local physicians to insure adequate medical service for their people.

MEDICAL SERVICE IN OUTLYING DISTRICTS

Eleven physicians are under contract with the Department to provide medical service in unorganized districts to indigent residents, and to perform the duties of Health officers in these districts. A contract is entered into between the physician located in these districts, and the Department, by which provision is made for the treatment of patients and the control of outbreaks of contagious diseases. The physician is paid according to the number of such unorganized districts served. For major surgical cases which the physician may be called to attend he is paid an additional amount over and above the contract, on the basis of the Workmen's Compensation Board schedule of fees.

There are, in addition, four physicians stationed in outlying districts remote from medical and hospital service of any kind. The salaries of these four physicians are paid by the Government, housing and transportation being furnished by the people residing in the district served. In some of these districts settlement is rapidly taking place but the people are carrying on under pioneer conditions and are, in most cases, quite unable to provide medical service out of their own resources. Those who are in a position to make some payment are charged a nominal fee for each visit.

PUBLIC HEALTH AND DISTRICT NURSES

Public Health Nurses

Public health nurses are in charge of child welfare stations in each of the cities of Calgary, Edmonton and Medicine Hat, and by arrangement, public health nurses are stationed in three rural municipalities; one half of the salaries being paid by the municipalities and one half by the Province. One public health nurse is engaged as a lecturer and demonstrator in home nursing and first aid, and visits small urban and rural municipalities at the request of local organizations. There has been quite a widespread demand for this type of service.

District Nurses

These are stationed in frontier communities in which neither medical nor hospital facilities of any kind are available. These district nurses are carefully selected and are required to have had special obstetrical training. They provide special service in first aid, midwifery, bedside nursing, child hygiene, and the many other services expected of them in a pioneer community. At the present time seven of these district nurses are stationed in pioneer communities which, with one exception, are located in the northern part of the Province.

During the summer months two or three public health nurses are employed in Travelling Child Welfare Clinic work throughout the

Province. Clinics are arranged by local organizations and the co-operation of local doctors is invited. These clinics deal almost entirely with children of pre-school age, the children being weighed, measured, inspected, and mothers advised with reference to diet and the correction of defects.

THE TRAVELLING CLINIC

The Travelling Clinic, for physical and dental examination, minor surgery and dentistry, is perhaps the most outstanding work of a special nature undertaken by the Department in recent years. In isolated districts far from railway, hospital and medical service, the work of the district nurse often presents problems the solution of which taxes her ingenuity. In such a contingency the Travelling Clinic was born. Often in the course of her work the nurse discovered—as she still discovers—children in urgent need of medical, surgical or dental attention, but owing to the distance from a hospital and physician and the expense involved, it was rarely possible to obtain this attention. Seeking relief from such conditions a plan of action was evolved. A number of such cases were assembled at central points and a doctor invited to make a visit and perform the operations found necessary, at a special rate. In 1924 the experiment was made and repeated in 1925 and 1926. During those years twenty-two clinics were held. In the fall of 1926 the experiment of placing the Clinic on a partly self-supporting basis was tried and on the experience gained in these experiments was based the policy of the Clinic as it has operated since that time. During the winter of 1926 and 1927 requests for the services of the Clinic became so numerous that thorough organization became necessary and an adequate plan of operation was devised for carrying on the work. Secretaries of school boards, women's organizations and other interested bodies were advised of the conditions under which the Clinic would visit their districts. (The Clinic only visits places to which it is invited). Following the request for the Clinic, the chief conditions are that at least twelve school districts shall combine for clinic purposes, and that a local committee be formed to arrange the details in connection with the clinic, such as the provision of a suitable building, water supply, heat, beds, bedding, etc., and in certain cases to act in an advisory capacity. On the completion of the local organization a public health nurse makes a preliminary inspection of all school children in the district and recommends to the Clinic all whom she considers should be examined by the physicians and dentists attached to the staff of the Clinic. The district is later advised as to the date on which the Clinic will arrive.

The personnel of the Clinic as operated in 1930 was: a surgeon, in charge, an examining physician and anaesthetist, two dentists and four nurses. On the first day of the clinic both physicians and one dentist

are engaged in the examination of patients, and parents are advised to have those requiring operations return on the following day. The other dentist carries on dental treatments and the nurses take charge of the clerical work and the organization required. On the second day the one dentist carries on with dental treatment and the rest of the staff are engaged in the operating room and the improvised hospital ward. The second dentist does extractions required, under general anaesthesia. The operating staff consists of a surgeon, anaesthetist and surgical nurse. One nurse is in charge of the sterilization of instruments and supplies and the other two nurses have charge of the patients both before and following operations. Patients operated on remain in the improvised hospital ward until the following day. On the third day the Clinic moves to the next centre, the itinerary being arranged so that this is within easy access. The parents are present during the examination of the children and this offers an exceptional opportunity to impart health instruction of which full advantage is taken. The outstanding features of the Clinic are: physical and dental examinations, minor surgery, dentistry, and health education, the latter alike by precept and example during a two day period of intimate contact with both patients and parents. A charge of \$15.00 is made for tonsil and adenoid operations and a proportionate charge for other minor operations. The charge for extraction of teeth is from 50c. to \$1.00 and for fillings from \$1.00 to \$2.00. No charge is made where financial circumstances are such that parents are unable to pay for this service. Physicians practising in proximity to districts visited are notified in advance of the visit of the Clinic and invited to co-operate in its work, and children examined at the Clinic are referred to their family physicians for the after treatment which may be indicated. Following the completion of the itinerary of the Clinic a circular letter and a progress report form is sent to the parents of children examined. The parents are asked to complete these forms and return them to the Department. In this way it is possible to appraise the service both from the physical as well as the educational point of view.

Several districts have made satisfactory arrangements with local physicians for a service similar to that given by the Travelling Clinic. At the request of local physicians in one district this year the Department sent a public health nurse to make the preliminary school survey and the doctors arranged to do the operative work found necessary at practically the same rate as the Clinic.

Following is a brief summary of the work of the Travelling Clinic from its inception up to the end of 1929:

No. of clinics held	184
No. of school districts covered	1,219
No. of children inspected by public health nurses preceding the clinic	24,000
No. of physical examinations by physicians	14,214
Total no. of operations	4,520
Total no. dental treatments	10,368

It is a great satisfaction to the Department and a tribute to the efficiency of the staff engaged in this work that not a single death has been recorded in connection with these operations.

DISTRICT HEALTH UNITS

It has long been recognized by public health authorities that the full-time service of a well qualified staff of public health workers is essential if we are to develop an efficient public health service. There has been little progress in rural as compared with urban public health work, largely because we have not had the necessary health machinery operating in rural districts.

At the Session of the Legislature in Alberta in 1929, an Amendment to the Public Health Act was passed under which the Minister of Health is given authority to establish "district health units" when requests are received from a sufficient number of municipal councils to warrant establishment of such units. Six rural municipalities together with the included towns and villages are considered the minimum number required to justify the establishment of a district health unit. The minimum staff of such a district health unit consists of a medical health officer, specially qualified in public health work, one or two well qualified public health nurses, a sanitary inspector and an office assistant or secretary-technician. In the office of the health unit it is proposed to establish a district laboratory to provide public health laboratory service. The annual budget of such a district health unit would be from ten to twelve thousand dollars. The unit would perform the older public health functions, such as the control of contagious diseases, sanitary inspection, inspection of food and water supplies, the registration of vital statistics; and the newer functions, such as the discovery and control of tuberculosis and venereal disease, medical inspection of pre-school and school children, periodic medical examination, conducting clinics and educational activities in pre-natal and post-natal work, and general health education among children and adults. The need for such work is evident in almost any of our small towns and rural districts, and the district health unit is the logical centre around which an effective public health organization should be built.

The Department has arrangements under way at the present time for the organization of two such demonstration health units, one at Red Deer and the other at High River. Organization is practically completed in these two districts and it is proposed to open these two health units in the spring or early summer of 1931. It is proposed to carry on the demonstration over a period of three years during which time the Rockefeller Foundation have agreed to contribute twenty-five per cent of the budget and the Province fifty per cent, leaving a balance of twenty-five per cent to be distributed among the municipalities included in the Unit.

MENTAL HEALTH

Mental Hygiene clinics were established by the Department in Calgary and Edmonton in the fall of 1929 and a third clinic has recently been established in Lethbridge. Dr. C. P. Fitzpatrick, Medical Superintendent of the Mental Institute at Oliver, is in charge of these clinics to which problem cases are referred by private physicians, welfare organizations, police magistrates and others. The establishment of these clinics marks an effort to apply the principle of prevention in the field of mental health. Psychiatric ward accommodation for 18 patients has been provided in the addition to the University Hospital which has recently been completed. This will meet a long felt need, enabling patients giving evidence of mental sickness to be brought under early observation and treatment. Dr. C. A. Baragar, formerly Medical Superintendent of Brandon Mental Hospital, recently received the appointment of Commissioner of Mental Institutions and Director of Mental Health for the Province. As the title of the position indicates, Dr. Baragar has been given general supervision and direction of all Mental Health activities in the Province.

THE SEXUAL STERILIZATION ACT

Following are the provisions of the Sexual Sterilization Act which was assented to at the 1928 Session of the Legislature:

1. This Act may be cited as the "Sexual Sterilization Act."
2. In this Act, unless the context otherwise requires—
 - (a) "Mental Hospital" shall mean a hospital within the meaning of the Mental Diseases Act;
 - (b) "Minister" shall mean the Minister of Health.
3. (1) For the purpose of this Act, a Board is hereby created, which shall consist of the following four persons:

Dr. E. Pope, Edmonton
Dr. E. G. Mason, Calgary
Dr. J. M. McEachern, Edmonton
Mrs. Jean H. Field, Kinuso.

 - (2) The successors of the said members of the Board shall from time to time, be appointed by the Lieutenant Governor in Council, but two of the said Board shall be medical practitioners nominated by the Senate of the University of Alberta and the Council of the College of Physicians respectively, and two shall be persons other than medical practitioners, appointed by the Lieutenant Governor in Council.
4. When it is proposed to discharge any inmate of a mental hospital, the Medical Superintendent or other officer in charge thereof may cause such inmate to be examined by or in the presence of the board of examiners.
5. If upon such examination, the board is unanimously of opinion that the patient might safely be discharged if the danger of procreation with its attendant risk of multiplication of the evil by transmission of the disability to progeny were eliminated, the board may direct in writing such surgical operation for sexual sterilization of the inmate as may be specified in the written direction and shall appoint some competent surgeon to perform the operation.
6. Such operation shall not be performed unless the inmate, if in the opinion of the board,

he is capable of giving consent, has consented thereto, or where the board is of opinion that the inmate is not capable of giving such consent, the husband or wife of the inmate or the parent or guardian of the inmate if he is unmarried has consented thereto, or where the inmate has no husband, wife, parent or guardian resident in the Province, the Minister has consented thereto.

7. No surgeon duly directed to perform any such operation shall be liable to any civil action whatsoever by reason of the performance thereof.

8. This Act shall have effect only insofar as the legislative authority of the Province extends.

While sexual sterilization should not by any means be regarded as a solution for the mental health problem it has a definite place in a well rounded mental health programme, and the law in Alberta is in line with the foremost thought of the day.

SPECIALISTS

Since 1926, legislation has been in effect in Alberta governing the use of the term "specialist" by members of the medical and dental professions. This legislation provides that no person shall advertise or hold himself out to the public as a specialist or as being specially qualified in any branch, or any class or system of practice without having received from the Registrar of the University of Alberta a certificate of having complied with such conditions precedent as to qualification or fitness, as may be prescribed by the Senate of the said university. The said conditions may be based either upon the possession of certain diplomas or other professional qualifications, or upon compliance with prescribed tests by way of examination or otherwise.

Since 1926 sixty-nine "Specialist" diplomas have been granted to physicians and surgeons and seven to dentists.

VENEREAL DISEASE CONTROL

This work is carried on under the direction of the Social Hygiene Division and is conducted along much the same lines as in the other Provinces. Clinics have been established in the cities of Edmonton, Calgary, Lethbridge and Medicine Hat, and facilities for diagnosis and treatment have been provided in the jails at Lethbridge and Fort Saskatchewan. Patients are treated free of charge at all clinics. Laboratory service is provided by the Provincial Laboratory.

TREATED CASES, VENEREAL DISEASES, 1929

	Male	Female	Total
Total cases treated.....	1,095	262	1,357
Total syphilis.....	308	112	420
Total gonorrhoea.....	757	150	907
Total chancroid.....	30	0	30

PROVINCIAL LABORATORY

The Provincial Laboratory is located in the Medical Building of the University of Alberta and the work is carried on under the direction of Dr. Allan Rankin, Dean of the Medical Faculty. Free laboratory service is provided for physicians, hospitals and local boards of health. The commercial value of the services rendered by the Provincial Laboratory is \$145,486.40, for 1929.

DISTRIBUTION OF VACCINES, SERA AND INSULIN

Vaccines and sera for prophylactic purposes are supplied free of charge by the Department. Sera for treatment purposes are supplied at a small margin over cost, sufficient to cover handling charges. Where serum is required for indigent patients the Department shares the cost of supplying such serum with the municipalities on a fifty-fifty basis. Insulin is supplied free of charge to patients who are unable to pay for same. As already mentioned, convalescent poliomyelitis serum is supplied free of charge. Some twenty-two hospitals are utilized by the Department as centres for the distribution of vaccines and sera and have given splendid co-operation in this work.

PUBLIC HEALTH EDUCATION

A new division of Public Health Education was established in 1928, in order to meet the rapidly growing demand for lectures, films, exhibits and literature dealing with various phases of public health. As already mentioned, classes in Home Nursing and First Aid are arranged at many points. During the year 1929, 143 lectures were given in 89 different places to 3,913 people.

Health educational work along the more popular lines is also carried on by a male lecturer. Moving pictures and lantern slides are used to illustrate health work in general as well as special features of the work carried on by the Department. During 1929, 161 such lectures were given in 100 different places to approximately 15,000 people.

REQUEST FOR JOURNALS

The Editorial Board would appreciate receiving copies of the issues of *February, March, April, August and September, 1930*. Acknowledgement will be made of receipt of any copies and postage charges will be returned.

The exhaustion of the supply of these issues and the requests received for additional copies to complete bound volumes by various libraries indicates the increasing interest which is manifested in our Association's Journal. Your co-operation with the Board in this matter will be of very real assistance.

Health and Sickness Insurance in Saskatchewan

F. C. MIDDLETON, M.D., D.P.H.

Deputy Minister of Public Health, Saskatchewan

THE principle of insurance has been described as a system whereby, in case of contingency, by uniting with others, each man may subject himself to a small deprivation in order that no man may be subjected to a great loss. Insurance schemes have been applied in very many ways, and are favourably viewed and accepted almost universally, so that it is not surprising to find many believers in insurance advocating its application in the prevention and treatment of disease.

In England and Wales in 1834, almost a hundred years ago, Poor Law Commissioners were appointed. It was soon observed by the commissions that a vast amount of the pauperism they had to deal with was the direct and immediate result of ill health due to inability to secure proper medical attention, so that the Poor Law medical service and Public Health medical service were introduced. It was found that the amount of relief required as the result of ill health made it good economy to spend money to prevent and properly care for sickness, and to this end it was recommended that district medical officers be authorized at the expense of the poor rate, to remove causes of disease, to suppress nuisances and to supply medical attendance and medicine to all the poor who might apply for it.

In Ireland in 1851, there had been established under the Medical Relief and Charities Act a universal dispensary system, freely available for the whole wage earning class without deterrent conditions or any stigma of pauperism and, in 1870, a system of free medical advice to the whole of the wage earners was under consideration by the Poor Law Board.

Recognition was given to a compulsory form of health protection in Germany in 1884-6, over forty years ago, when a compulsory scheme of insurance against sickness and accident (including medical treatment for wage earners) was brought into operation. A little later Austria adopted a somewhat similar scheme and in 1911, state health insurance was introduced into Great Britain and Ireland by the British National Health Insurance Act. Although this included a scheme of unemployment insurance, its principal objects were insurance against loss of health and disablement, and for the prevention and cure of sickness. It is compulsory for all employed persons over 16 years of age. Over fifteen million people, one-third of whom were women,

were brought within its scope. The scheme has been enlarged so that now it is estimated there are seventeen million included and the number directly affected as actual or potential beneficiaries is placed at thirty-one and a half millions. It is considered that in the United Kingdom, with the Workmen's Compensation included, industrial workers are given more state protection than in any other country, and there is no doubt that in the efforts being made to solve the problem of caring for the sick, what has been accomplished in the old land is to some extent being reflected in Canada.

In 1927, at the International Labour Conference of the League of Nations, matters relating to sickness insurance for workers in industry, commerce and domestic service, as well as for agricultural labourers, were discussed, and in these discussions the opinions expressed were to the effect that compulsory state insurance was likely to spread rapidly. It was pointed out that those in the older age groups, those in ill health, and many women were eligible to be accepted by a voluntary agency or friendly society, and therefore the state should be partially responsible. Further, there is a mutual interest by the employer, the employee and the state in the physical well-being of all individuals and in the maintenance of the health of workers. It is well known that from a financial viewpoint people are conveniently divided into three classes: the poor, the middle class and the well-to-do. The poor must be provided for by organized society. The middle class forms the larger group in Canada. These are the hard working, industrious labourers, tradesmen, agriculturalists, etc., who are endowed with a desire to pay their accounts, to be independent and not to accept charity. Unfortunately it is not always possible to maintain this enviable position. The rich, of course, are able financially to look after themselves.

At the present time, in Western Canada particularly, co-operative systems of buying goods, and of selling grain and produce are being practised very largely. There is the wheat pool, the coarse grain pool, the egg pool, the poultry pool, and the co-operative store.

Saskatchewan has adopted the co-operative or pooling system to a greater degree than the other western provinces, so that we might expect to find the people of Saskatchewan applying co-operative or pooling principles to such matters as medical, nursing and hospital service. As applied to the care of the sick such a co-operative system might be considered as a form of health and sickness insurance. The particular type of health and sickness insurance adopted in different parts of the Province has been determined with a view to meeting local conditions.

The population of Saskatchewan is 75 per cent rural. Doctors and nurses naturally drift to the larger centres on account of the hospital facilities which are found there, and it has been found necessary to offer some inducement to physicians to have them remain in a rural

district. This situation has been very largely met by the employment of the municipal doctor.

The Municipal Doctor

A rural municipality is an area about 18 miles square. Permissive legislation has been enacted whereby a rural municipal council may submit a by-law to be voted on by the electors, empowering them to engage the services of a physician, at a salary not to exceed \$5000 per annum. If the vote carries the ratepayers tax themselves to provide this service and they are then entitled to medical attention without further cost. Twenty-one rural municipalities have employed full-time municipal doctors, a number of others are voting on the scheme in December and a great many others are contemplating doing so. The success or failure of the scheme depends largely on the doctor employed.

A municipal council has also power to give a grant or bonus to a doctor up to \$1500 per year as an inducement to such practitioner to reside and practise his profession within the municipality, the primary purpose being to ensure that medical service is within a reasonable distance of those concerned. Some thirteen municipalities pay grants varying from \$900 to \$1500 a year.

The Municipal Nurse

A municipal council may engage the services of a nurse for the municipality, and different arrangements are made for this purpose. In some instances the municipality pays the nurse \$500 a year as a bonus to remain in the municipality and then those requiring her services pay her only \$2.50 per day instead of the usual rate of \$5.00 per day. One municipality permits its municipal doctor to employ a nurse for any case he thinks requires a nurse, and the municipality pays the account with a limit of fifteen days for any one case in a year. This municipality furnishes a nurse at its expense for all maternity cases, and in a period of six years they had 185 births with no maternal deaths. The infant mortality rate was only 48.7 per 1000 living births during the same period, and not one death from a communicable disease occurred.

In the Cumberland House district in the far North the Government has stationed a nurse to help care for the residents there. There are fourteen government public health nurses located in various parts of the province.

The Victorian Order of Nurses has experimented in three rural municipalities by placing one of their nurses in each of these districts, to do visiting bedside nursing the same as they do in urban centres. The financial arrangement is that the Victorian Order pays the salary of the nurses and supervises their work; each municipality in turn gives a grant to the V.O.N. organization, and the patients pay when

they can a very nominal amount for each visit. The Department of Public Health has supplied each nurse with a car and is responsible for transportation. The intention is to demonstrate the possibilities of such a scheme and then to have the municipalities take over the work at their own expense. In two districts in the hinterland, Meadow Lake and Ile à la Crosse, the Government gives a bonus to each of two doctors as an inducement to them to remain in this unorganized territory, and at Ile à la Crosse the Dominion Government has built a hospital in which are treated Treaty Indians and half-breeds mostly.

Sanatorium Treatment for Tuberculosis Cases

The Government has built and equipped three sanatoria for tuberculosis cases, and they are operated by the Anti-Tuberculosis League. For all cases of tuberculosis who have resided in the province for six months, treatment in a sanatorium is provided at no expense to the patient. The operating cost of the sanatoria is provided by the Government paying one dollar per patient per day, the rural and urban municipalities contributing the balance. The rural municipalities pay 60 per cent of this balance and the urban municipalities pay 40 per cent.

The Anti-Tuberculosis League sends one of its doctors to the various centres to hold chest clinics, and any suspected case may be referred there by the attending physician. In addition, where no clinics are held, the travelling diagnostician will arrange to visit the rural physicians for purposes of consultation. The League further will pay to any family physician the sum of five dollars if he examines a tuberculosis contact. In this way it is hoped to find these cases in the very earliest stage possible.

Venereal Disease Dispensaries

The Department of Public Health with the assistance of the Federal Government has established seven venereal disease dispensaries, where free treatment for these diseases may be obtained. The Department also provides treatment for all cases admitted to the jails, and will furnish the necessary drugs for the treatment of indigents who are unable to attend any of the dispensaries.

Trachoma

In those districts where trachoma exists, a government nurse visits the cases regularly to assist them with the treatment and to see that it is carried out properly. The municipalities in which trachoma exists are expected to contribute half of this expense.

Vaccines, Sera and Immunization

The Department of Public Health furnishes free to doctors and hospitals,—smallpox vaccine, typhoid vaccine, rabies vaccine, diphtheria antitoxin, toxoid and Schick tests, scarlet fever antitoxin, toxin

and Dick tests, anti-meningococcus serum, tetanus antitoxin, silver nitrate solution for prevention of ophthalmia neonatorum, and convalescent serum for poliomyelitis.

In many of the municipalities financial arrangements have been made with the local doctors by the councils for vaccinating the children against smallpox and protecting them from diphtheria with toxoid. This is now being considered a community responsibility.

Hospital Treatment

There are sixty government aided hospitals in Saskatchewan, twenty of which are "union hospitals". Many of the municipalities in the "union hospital" scheme have taken advantage of existing legislation permitting them to tax themselves to pay for the hospital treatment of their ratepayers. That is the hospital fees are paid through taxation, in a manner very similar to that in which a school is supported. There are many different arrangements made with such union hospital boards. In some cases the whole hospital fee is paid by the municipality; in others the patient pays a very nominal hospital charge, possibly one dollar per day and the taxation takes care of the balance of the cost. In some the number of days treatment for each ratepayer during a year at the expense of the municipality is limited. In others only the hospital fees for maternity cases are paid by the municipality.

In all cases where the union hospitals are established, even though free hospitalization is not provided, all deficits are made up by the co-operating municipalities, so that these hospitals are always in a good financial position and their support is no longer haphazard, and dependent as formerly on bazaar drives, fees from entertainments, etc.

In one union hospital at Rosetown where treatment through taxation is adopted, the following arrangements are made: Two municipalities pay the hospital fees of all resident ratepayers, their dependents, hired help, and school teachers, if resident for thirty days; two others pay the same, only that school teachers are omitted; one municipality not in the union hospital scheme also pays for the hospital treatment of its resident ratepayers, and another not in the scheme pays \$2.00 per day towards the hospital expense of its ratepayers. One village pays for twelve days hospital treatment in any one year.

The organizing of union hospitals has in many cases been the means of retaining a medical service in a district where otherwise none would be available.

To all government aided hospitals a government grant of fifty cents per patient per day is paid and to the sanatoria a grant of \$1.00 per patient per day is paid.

Maternity Grants

Realizing that many expectant mothers who reside remote from

any medical, nursing or hospital service may, for financial or other reasons, be unable to have the services of a doctor at their confinement, the Government pays a maternity grant of \$25.00 toward this expense to those who come within the provisions of the grant. In 1929, 1122 mothers were assisted with the grant and \$25,258.00 was expended.

The Workman's Compensation Act recently passed should result in more safety appliances designed to prevent accidents, and the prompt and assured care given to the injured aids in a more speedy recovery. This Act should also result in preventing occupational diseases.

Full-Time Health Units

As yet only one full-time health unit has been established in Saskatchewan. This consists of 8 rural and 15 urban municipalities, and is staffed with a full-time medical officer, a full-time sanitary officer, a full-time public health nurse and a secretary-technician. The municipalities provide one half of the operating expense, and the Government assisted by funds from the Rockefeller Foundation provides the balance. The total annual cost is about \$14,000.

Mental Hospitals

Providing hospital facilities and medical care for those suffering from mental disease at the expense of the State has long been a recognized arrangement, and the time has now arrived when Saskatchewan is attempting through the operating of psychiatric wards, staffed by specialists in this line of work, to apply prevention methods, by encouraging these cases to make use of these psychiatric wards in the early stage of the disease. It is hoped this system will obviate the necessity of having at least a fair percentage of mental cases go to the mental hospitals.

The Department of Public Health provides free laboratory service for examination of bacteriological and pathological specimens sent in by physicians.

Pre-school examination clinics have for some time been carried on by the Department.

Saskatchewan has been the first province in the Dominion or state in the Union, with the exception of Massachusetts, to recognize cancer as a public health problem. The Saskatchewan Cancer Commission Act, which is administered by the Minister of Public Health, provides that the Government may purchase radium for the treatment of cancer and also provides for the organization of cancer clinics at various centres. It is expected that an emanation plant will be commenced at the University of Saskatchewan early in 1931.

The Department of Indian Affairs already provides for both part and full-time medical service for the Indians.

Veteran soldiers under certain conditions are entitled to medical treatment through the Department of Pensions and National Health.

Railroads, industrial organizations, work camps, insurance companies, etc., find that, by adopting contract medical practice, much loss of time through sickness among employees is eliminated and the employee is able to do more and to do it better as a result of the health protection provided,—hence improved service and greater production. Voluntary organizations such as the Red Cross, which operates some fourteen Red Cross Outposts and a small hospital in Regina mainly for crippled children, as well as the Canadian National Institute for the Blind, which does a good deal of preventive eye work and otherwise assists the blind, contribute in no small degree to the needs of many cases who might otherwise be neglected.

There are numerous forms therefore of what might be termed health and sickness insurance, operating in the Province of Saskatchewan, local conditions largely determining which particular form or system shall be adopted.

It will be noted also, that the preventive phases and curative phases often have no sharp and distinct demarcation, but rather dovetail one into the other. Regaining health and maintaining it go hand in hand.

In this period of evolution of medical services the medical profession must be prepared for constructive leadership, and the public must also be made to realize that much of the present day sickness and ill health is unnecessary and can be prevented and eliminated, provided they are prepared to take advantage of and apply the knowledge gained through medical science, in the diagnosis, treatment and prevention of disease.

UNDULANT FEVER

THE fact that the infection in cattle is so widespread and affects so large a proportion of our cattle, and that such large numbers of our population are exposed to cattle infection, either by coming in contact with placental or fetal tissues which teem with abortion infection, or by consuming raw milk, cream or other raw milk products, which have resulted in comparatively few infections in human beings, has caused and still causes many to hesitate to accept cattle infection as a factor in the cause of undulant fever. These conditions simply indicate that man is very resistant to the bovine virus; nevertheless, the evidence now at hand forces one to the conclusion that certain infected cattle eliminate organisms belonging to the genus *Brucella*, which, under conditions not yet definitely understood, are capable of inducing symptoms of undulant fever in certain especially susceptible individuals.—*Animal Infections with Bacteria of Genus Brucella and their relation to Undulant Fever of Man*, by J. Traum.

Public Medical Services in Manitoba

F. W. JACKSON, M.D., D.P.H.

Deputy Minister of Health and Public Welfare, Manitoba

WHEN one comes to make a study of state medicine in the Province of Manitoba the question immediately arises as to just what medical activities should be classified as forms of state medicine. Should we classify certain types of public health work which are done by practising physicians as varieties of public medical service, or should all public health activities be classified as state medicine? For the sake of clarity in the discussion of this subject in respect of Manitoba certain work of a public health nature which is being done by private physicians, and paid for by public bodies, will be classified as public medical services.

In the first instance it would seem that there is not as much advance towards province-wide state insurance, or state medicine, as in some of the other western provinces, notably British Columbia and Alberta, but at the last session of the Provincial Legislature a leading resolution was brought up on the floor of the House and was passed almost unanimously. A synopsis of the resolution is as follows:

WHEREAS, owing to fear of inability to pay, many persons do not avail themselves of medical services and hospital facilities;

AND WHEREAS, the public health is a matter of paramount importance, not only to the individual, but also to the State;

AND WHEREAS, it is in the public interest to extend the practice of preventive medicine and to make more readily available medical services and hospital facilities to a greater number of persons;

Be it resolved, that the Minister of Health and Public Welfare be requested to consider the making of a comprehensive departmental enquiry and report to this House regarding the following matters, namely:

1. Preventive medicine.
2. Municipalization of medical and hospital services.
3. Logical health areas.
4. Health insurance and other practical methods for the more equal distribution of the cost of illness.
5. Public medical services.
6. Practical methods for making special required methods of diagnosis and treatment in certain diseases more readily available.

Such departmental report to form the basis for investigation and consideration by a special select committee of this House, to be later appointed for the purpose of co-operation with the Minister of Health and

Public Welfare in the formulation of a comprehensive public health scheme for the Province of Manitoba with a view to providing more efficient and economical public health services.

It will be seen by this resolution that the Department of Health and Public Welfare has been asked to make a comprehensive enquiry on various subjects, some of which, in fact nearly all of which, are forms of state medicine. A report of this enquiry is now in the course of preparation.

It is rather fortunate, we think, that the preliminary move towards national medical service should come about in this way, as certainly the Department of Health will be more likely to supply unbiased information than either a lay or professional group.

MUNICIPAL HOSPITALS

In so far as the individual movements towards public medical service are concerned, we have these already in the Province. The first of these, of course, is the municipal hospital movement. At the present time in Manitoba there are four municipal hospitals, all situated in small towns and serving, practically entirely, rural areas. These four hospitals contain 57 beds, which are devoted to medical, surgical and obstetrical services.

Under the Municipal Hospital Act of Manitoba, any municipality, union of municipalities, or parts thereof, can, with the permission of the Department, form a hospital district and establish a municipal hospital. The capital required to establish the hospital is supplied by the district itself, and levied for in the taxes. The running expenses, less the revenue, are also a direct charge on the district. As yet none of the established municipal hospitals make any special rates for hospital-tax papers, although under the Act this can be done if the Hospital Board so desires. So that the only evidence of public medical service in this scheme of the municipal hospital, as we know it in Manitoba, is that the people tax themselves in the first place to establish a hospital, and in the second place for the funds to keep the hospital running as a going concern.

The one disadvantage in this municipal hospital scheme as we have it is that we are likely to find parts of the country over-hospitalized, while other parts have insufficient hospital accommodation. For instance, the people in "A" decide they would like a municipal hospital, and an area is formed, the scheme voted on and passed, and a nice new up-to-date hospital is established and seems to fill the needs of the community. "B," situated some ten or fifteen miles from "A," and rather jealous of "A" as a centre, decide they also should have a hospital, so they form an area, vote on the scheme and erect another municipal hospital; so we have two small hospitals in a district that

should be looked after by one medium-sized institution. It would seem that the only way to overcome this would be for the province to be divided into hospital districts, and the hospitals erected to be confined to these districts.

THE MUNICIPAL DOCTOR

Another form of municipalization in the care of the sick is the appointment of municipal doctors. Provision is made in the Municipal Act in the Province whereby a municipality can vote on the advisability of employing a medical man on a full-time basis to look after the sick in the particular municipality in question. So far there are three such full-time municipal doctors in the province. One of these projects has been in operation for the past eight years, and appears from every angle to be working out satisfactorily. The other two, although not having been in operation so long, also seem to be getting along well. It would appear that it depends a great deal on the type of medical man employed, and also on the type of population he has to serve. Under the Act the municipality can vote on such a scheme if any twenty-five ratepayers present a petition to the municipal council asking for the appointment of a municipal physician. The maximum sum allowed in the Act to be raised for such a service is \$5,000.00 per year. Naturally the municipalities, as a rule, try to get a physician as cheaply as they can, and, if they allow this to be the main consideration in employing a medical man, it will tend towards giving them indifferent medical service, as it is reasonable to suppose that only those medical men who have been unable to make a success of practising on their own will be available for these appointments if small salaries are offered. The scheme, however, has its advantages in certain parts of the Province, particularly those which are settled by "new Canadians" of foreign extraction, as these people are loth to spend money for the care of their sick. When a municipal physician is available, however, he is called very often early than late, and he is, therefore, able to be of greater service. There is also a distinct advantage from a public health standpoint in that the medical man uses all the recognized methods for disease prevention, such as medical examination of school children, vaccination against smallpox and diphtheria and typhoid fever immunization. We find this to be the case in the three municipalities we now have under municipal physicians, and in all instances school children are medically examined, vaccinated and receive toxoid. The same holds good in pre-natal care. One doctor expressed himself as follows:

"Previous to being employed as a municipal physician in this municipality I never had the opportunity of seeing a woman to give her pre-natal care, and only attended about 10 per cent of the confinement cases, usually being called because something had gone wrong.

In the last five years, since being a municipal physician, I have attended 100 per cent of the maternity cases in this municipality, and practically every woman received prenatal care."

The municipal doctors tell their side of the question in the following quotations:

1. "The public as a whole does not take advantage of you, because you are a municipal doctor. Some individuals do—just as in private practice where they probably would not pay you anyway. You soon find out who these people are, and, after a couple of unnecessary trips, you learn to be busy when they phone and tell them to try some simple remedy, and let you know later. If they persist you tactfully explain that for minor things they must come to your office, as you are so busy you will be neglecting serious cases if you run around to mild ones, and they shouldn't want that, especially as some day they might be the serious cases. My hardest cases to get to the office are people who live at a distance and haven't a car. They would much rather call you out than hire a car. Again, you must explain firmly that you are sorry they have no car, or that it is broken down, but they must come to you. Some people hate to bother you for fear you think they are imposing. They often do not call you when they should, so these trips you probably should have made but were not called practically balance the unnecessary ones you do make.

"I do not consider that I receive enough pay for the work done. I am doing about \$7,500.00 worth of work and receiving half of that. I think \$5,000.00 a year, with the municipality paying all livery expense, would be fair. In private practice you have always a percentage of bad accounts, expense of collection and worry in bad years, so I think if you get two-thirds of what you earn, and paid monthly, so you have no worries, you are pretty well paid.

"I think any good doctor, whose heart is in his work, must practise preventive medicine. Being a municipal doctor is perhaps an added incentive to do so, and you are certainly in a much better position to do so, especially if you are also the health officer. You can be much more strict in your quarantine and isolation of mild or suspicious cases when you have no financial dealings with your patients. Also they are much more willing to be vaccinated when they do not pay for it in any way. Some are anxious to have their children protected, but others are afraid they will have a sore arm; some of them are just neglectful, but these can be persuaded. They still need a lot of education along these lines, although a small epidemic nearby does frighten them and assists a lot in getting them done.

"Being a municipal doctor does encourage pregnant women to call on you for a confinement. Only one, in a year, has been handled by a midwife, even among the foreigners. For pre-natal and post-natal care, I think they will come in more freely and better than in private practice, but many do not realize the benefit and need education. They do come about their babies, especially artificially-fed ones.

"I think there should be a central medical board, probably chosen from the M.M.A. College of Physicians and Surgeons and the Provincial Board of Health, to be consulted by any municipal council wishing a municipal doctor. They could tell the council what salary they should pay. This, I think, should be figured out on a population and area, or mileage, basis. There should be a minimum salary of at least \$3,600.00 per year, with livery paid by the municipality in all cases. The municipality should build a suitable house and office for rent, unless there is one. This central medical council

could help the municipal council to choose a doctor, and could act as arbitrator in any dispute between the council and the doctor. A municipal council who are ignorant of other medical ethics and practice cannot judge very well when complaints are made whether they are *bona fide* or otherwise. A doctor should not be hired or fired before consulting this medical council. It would be a kind of court of appeal for both sides, and, in case of dispute would send out a disinterested medical man to get both sides and report to the medical council, who would then give its decision as to who was in the wrong. This is only a passing suggestion, and I really haven't the details all worked out, but you will probably get my idea. Myself, I am a booster for the municipal doctor. It is a good thing for the people—gives them equal care, rich or poor, and at a reasonable rate; it certainly tends strongly towards preventive medicine, and the doctor must preach hygiene to help himself. It is a good thing for the doctor, too, if he is fairly paid and not imposed upon, or over-worked. Surely he can give better service when he is not worried over collections, and he will go more readily to the poor when they don't already owe him plenty of dollars which he knows he will never get."

2. "I came to this municipality on August 1st, 1921, and had a heavy private practice from then till June 1st, 1922, when I went on a straight salary of \$3,300.00 per year, no bonus. I found collections terrible, and was going to quit, when a vote was taken to put me on a salary. This vote only carried by a majority of 25, but after trying the system out till December, 1922, when another vote was taken, over 80 per cent of the people voted for the system at that time, and since then the question of a vote has never been mentioned. I am getting a salary, and the people, I trust, are getting a good medical and minor surgery service at least.

"I have been very successful in keeping unnecessary calls down to a minimum. When I get a call of a suspicious nature, I say: 'If you had to pay me \$1.00 per mile would you come to my office or would you send for me?' Again, I pay my own car expenses in the summer, but the people have to pay livery charges in winter. This may be some help. The reeve and council co-operate very nicely with me. I think there is very little need for worry on the part of the medical man on this account.

"The percentage of pregnant women who seek assistance is practically 100 per cent in this municipality. Even the Ukrainian district, which never employed a doctor before, calls me in for every maternity case, and the old superstitious midwife is being gradually driven out as 'absolute control' in these cases. The same applies to post-natal care.

"To give a doctor a salary and then allow him to charge extra fees for maternity work and minor surgery, or charge a percentage of present mileage fees, in my opinion would not be a salary proposition, but would be a bonus scheme."

3. "*Re Unnecessary Calls*—In this municipality when my contract was discussed with the council, this problem was considered. The council agreed to investigate any case which I would report, and promised to warn the party that if unnecessary calls were being made, a special fee would have to be charged such persons. At the start a few unnecessary calls were made, but I have been able to deal with the individuals myself, and for the past six months there have been very few unnecessary calls.

"I have immunized the children in all the schools against diphtheria, and I have also vaccinated the pupils, also have done both to many under school age. It would be almost impossible to negotiate with school districts to have this work done, if a fee were to be charged. Although in private practice the incentive to do this work may be just as keen, the difficulty in putting it over would be too discouraging.

"My visits to the schools have also been the means of making a sort of wholesale improvement in many of the pupils' mouths, skin (scabies and impetigo), and also in overcoming the great difference between the amount of clothing of the boys and girls of the classroom. I have every school with a thermometer given a scheme for ventilation, and have got the boys to reduce the amount of clothing worn during school hours.

"This is my only experience as a municipal physician. I believe my contract is fair, and sufficiently comprehensive to the ratepayers, and at the same time offers encouragement to the physician."

From the standpoint of the public we find the opinion pretty generally expressed that the municipalization of physicians is advantageous. The following are quotations from letters from the secretary-treasurers of the municipalities where municipal physicians are employed:

1. "When the matter was submitted to a vote of the ratepayers it was carried by a rather small majority, the vote being,—for the municipal doctor 203, against 163. After a year's experience I am satisfied that if the question again came to a vote at least 80 per cent of the ratepayers would vote in favour of the doctor."

"In time the ratepayers may make more use of the doctor in a preventive way, but at present the majority do not call the doctor any sooner or oftener than they would if they were paying for the calls. As the people become educated to consulting the doctor in his office, as they are encouraged to do, the benefits will become more noticeable.

"The only drawback, in my opinion, is that the people are dependent on one doctor, who may be overworked on many occasions. They are naturally averse to calling in another doctor at their own expense. This can only be overcome by the fullest co-operation between the municipal doctors and those in private practice.

"In conclusion, I may say, that the success or failure of the municipal doctor scheme depends entirely on the doctor employed. Our experience has been entirely successful, because we have been fortunate in securing the services of a splendid man, and as long as we have his services the scheme will be a success. Regulations cannot affect the character of the man employed and the right man for the job is the prime requisite."

2. "The people are very well satisfied indeed, so much so, that they would never dream of going back to the old-fashioned hit-or-miss expensive method of medical attention. As far as this manner of medical service is concerned in this municipality it is an unshakable fixture.

"There is no room for doubt that it has not only tended to reduce sickness and the number of deaths, but that it has actually achieved this desirable result.

"As far as this municipality is concerned there are no drawbacks, but it has occurred to me that in some cases there might be the following: The ratepayers might call the doctor for every trifling ailment and keep him on the road and out of bed all the time. The doctor, on the other hand, might think that there was no occasion for him to keep abreast of the times, and would lose the development that comes from keen efficient competition, as his position and living are assured, for the time being, at any rate. In this connection I would suggest that the physician be required to take a post-graduate course at least every two years, not necessarily in some large American city, but at least in one of the Winnipeg hospitals. In any event a post-graduate course of some kind should be insisted upon.

"It must be borne in mind that up to the present at least the work so far is carried on in the country, and the doctor must be "country-minded" with a distinct tendency toward "city hospital" efficiency. He should take the engagement because he feels convinced that he can do his best life-work there, and not be casting envious glances at his city brother practitioner. Nor should he consider this position as a stepping stone to some other highly specialized work in his own chosen profession. Unless we can secure men who will look upon this work as a desirable permanency, the scheme is ultimately doomed to failure, no matter how apparently secure it seems right now to be entrenched. In my own mind, the municipal physician is here to stay, for the simple reason that it works out to the benefit of both parties concerned, and no one ever willingly relinquished that which he considered valuable to himself without being assured of something better.

"There is one thing in connection with this type of medical service which I think is due to develop and must be provided for somehow in the near future. This is the providing of central hospitals at some convenient points, thoroughly equipped and properly staffed with skilled surgeons and trained nurses. The ratepayers are in the habit of paying a flat tax (or fee) for medical attention, and in the majority of cases cannot afford to pay for expensive operations, no matter how necessary they may be. In my view, there should be hospitals located at Neepawa, Minnedosa, Dauphin, etc., Portage and Brandon, etc., or some other convenient points for their respective districts. These hospitals should be kept up and maintained to some extent by the surrounding municipalities, and the staff should be experts in surgery and specialists in their own fields, and, of course, should be engaged by the municipalities and paid a salary commensurate with their skill and ability.

"The ratepayers of the surrounding municipalities would thus be able to have the services of these men, as well as those of their own local municipal doctor, without, as now, paying the high fee, as this would be included in the municipal physician tax, and it would not be so very much more. Remember, I am not criticizing, or even calling in question the fees of the expert surgeons, but I am sure that this municipal physician scheme will work out so that all can get the services for a small cost (and the surgeon still be well remunerated), that are now the privilege of the favoured wealthy few. If some such scheme were adopted, then only a very few would require to go to Winnipeg for medical attention, or even to Mayo's, owing to the fact that their malady could be given attention in time and thus stop its malignant development.

"The ordinary municipal physician should be able to do minor surgery without the assistance of another doctor. He ought to be able to take out adenoids and tonsils and extract teeth. Our own physician does this kind of work and saves the ratepayers every year a large amount of hospital fees and other surgeons' fees as well. I think it should be required of every municipal doctor that he has some special training in surgery. A doctor that cannot do minor surgery is of no use to the ratepayers, except for bedside treatment, and the ratepayers expect minor surgery to be done as a matter of course and look for it in the contract. He should also be an expert in maternity work—there is no room for argument there. A large amount of a doctor's work will be of this nature, and he will be consulted before the actual confinement, as the people are beginning to appreciate that the actual delivery is a small part of the medical attention that can be given to this class of case.

3. "The council considers that where a municipal physician is employed, no person should be admitted into a public ward of a general hospital, the account of such a patient reverting to the municipality, unless that patient is admitted on the authority of the said physician. This could be remedied by an amendment to that effect in the Hospital Aid Act.

"I certainly think that this medical service is the best method if one gets the right man. I would like to see the service standardized. The success of the whole scheme depends on the doctor; if you get a good man who is interested in his work and in the health of the municipality, it cannot be beaten."

These are extracts from letters received as a result of questionnaires sent out to the doctors and clerks of the municipalities employing municipal physicians, and are self-explanatory.

THE BONUS SCHEME

Besides these three full-time municipal doctors, there are some seventeen physicians who receive financial inducement from their municipalities. This financial consideration ranges from \$25.00 to \$100.00 per month, and is often paid just in the form of a bonus and charged back to the residents of the municipality in their taxes. Sometimes, a municipality makes a stipulation that certain types of preventive medicine, such as medical examination of school children, vaccination, etc., shall be done without any further cost to the ratepayers.

Specific Immunization Services

There is another form of medical service which really comes under the classification of public health work, but which might also be taken as state medical service. I refer to the immunization programmes as put on in this Province. During the past year the local municipal councils themselves have expended approximately \$40,000.00 for toxoid administration and vaccination. This money is taken directly out of the taxes and paid to the local practising physicians for doing the work.

Distribution of Biological Products

The Provincial Department of Health distributes free for the treatment and prevention of disease the following biological products:—diphtheria antitoxin, diphtheria toxoid, Schick test, scarlet fever antitoxin, Dick tests, scarlet fever toxin for active immunization, typhoid vaccine, typhoid-paratyphoid vaccine, smallpox vaccine, anti-meningococcus serum, tetanus antitoxin, and convalescent anterior poliomyelitis serum. Besides these twelve, silver nitrate solution in ampoules is supplied to physicians for instillation into the eyes of newborn babies, and insulin is supplied free to indigent patients.

Tuberculosis

In 1929 there was an act passed by the Provincial Legislature called the Tuberculosis Control Act. The purpose of this was to unite all the anti-tuberculosis activities under one head, with the hope that by doing this greater efforts might be put forth for the control of this

disease. Besides the usual sanitarium treatment given for people ill with the disease, a determined effort has been made by a travelling clinic supplied by the Ninette Sanitarium to visit the various parts of the Province and examine all known contacts and cases of tuberculosis. During the past two years, clinics have been held at thirty-seven points in the Province of Manitoba, and over six thousand contacts have been examined. The cost of this service has been very small, running to approximately \$1.00 per head for those examined. This examination included, of course, the taking of X-ray plates. The clinics are held with the co-operation of the local practising physicians to whom the reports of the examinations are sent.

Bacteriological Laboratory Services

The Provincial Bacteriological Laboratory supplies the following services to all physicians and hospitals throughout the Province:—examination of sputum, urine and urethral smears, does Widal's and Wassermann's, makes bacteriological examinations of milk and water, and collects and prepares convalescent polio serum. All these services are done free of charge for the people of the Province, funds being supplied by the Department of Health and Public Welfare.

Trachoma

During the past year a definite effort has been made to estimate the amount of trachoma amongst the Mennonites in the Province. Three public health nurses who could speak German or Mennonite were engaged and given some special training at the eye, ear, nose and throat section of the General Hospital. They were sent out to the districts settled by Mennonites, and made a house-to-house canvass in these districts. In all, some ten thousand individuals were examined, and of this number twenty-two hundred were found to have some diseased eye condition, a thousand of which were suspected of being trachoma. When this report was completed, clinics were established at six points in this district, which were presided over by members of the Eye, Ear, Nose and Throat section of the Winnipeg Medical Society. Unfortunately, during the time of these clinics the weather was not favourable, and the attendance was not what it should have been. Previous to the holding of the clinics, all those individuals who by the nurses' survey showed diseased eye conditions were invited by letter to attend the eye clinics. Altogether, the oculists examined some 791; 192, or 24 per cent, were diagnosed as trachoma, and 181, or 23 per cent, were diagnosed as being suspicious, so that altogether 47 per cent of those examined were found to be in need of attention or supervision. If this percentage holds good throughout the Mennonite Reserve, we would expect that there are some twelve hundred individuals who are infected with trachoma. In all cases attending the clinics which required treatment, treatment was started, and the local physician

instructed as to how it should be carried on. It is hoped that special arrangements will be made with local physicians to set aside a certain specified time each week for the checking up of these cases, and a nurse or two will be put into this district to round the cases up and have them come into the clinics at the appointed time, and as well will do educational work amongst this population through the schools.

Medical Examination of School Children

Eight rural municipalities have employed a health officer to do medical examinations amongst the school children, using the special forms supplied by the Department. In all, close to three thousand children have been examined during the past year, over 70 per cent of whom are found to be suffering from some physical defect. The Department besides supplying the forms required usually gives to the local doctor any nursing assistance he may require and contributes to the municipality 25c. per head for each child examined, provided the administration of toxoid goes on at the same time.

In conclusion, one might venture to prophesy that the present financial condition of most of the rural dwellers in the Province will have a tendency to create more discussion of, and possibly a definite movement towards, Province-wide public medical service, which would include medical, nursing and hospital care of the sick.

SERUM TREATMENT OF TYPE I PNEUMONIA

Type I serum is no longer in the experimental stage. When administered early and in adequate dosage, the clinical results are striking. The present study demonstrates that concentrated serum possesses all the therapeutic value of the unconcentrated preparation. Furthermore, concentrated serum has a much higher potency and a lower content of chill-producing substances and horse serum proteins which make it more easily administered, and less frequently followed by chills, serum reactions and serum sickness. *Pneumococcus Type I Pneumonia, A Study of Eleven Hundred and Sixty-one Cases, With Especial Reference to Specific Therapy*—Russell L. Cecil, M.D., and Norman Plummer, M.D.—*The Journal of the American Medical Association*, Vol. 95, No. 21, November 22, 1930.

League of Nations--Sixteenth Session of the Health Committee

PRIOR to the formation of the League of Nations, the organization known as the Office International d'Hygiene publique (International Public Health Office), with headquarters in Paris, was established in 1908, and since then has had a continuous and useful existence. It consists of a standing committee which meets twice a year at Paris, and a small permanent secretarial staff, including a director. In the organization of the League, a comprehensive health section has been developed, consisting of an Advisory Council, Health Committee and a permanent secretariat.

Advisory Council

The Advisory Council is constituted by the Standing Committee of the Office International d'Hygiene publique, which body consists of delegates from the public health services of those governments which have ratified the Rome convention (45 at present). The Council receives all reports of the Health Committee which may refer to the Council any matter in which its advice or opinion may be desired. By this arrangement these two international organizations, each separate and independent, are closely related in actual work.

Health Committee

The Health Committee of the League is a body of experts in hygiene to advise the Assembly and Council of the League of Nations on matters relating to international health. There are twenty-seven members, each appointed to serve for three years. Canada has been honoured this year by the appointment of Professor J. G. FitzGerald, Director of the School of Hygiene and Connaught Laboratories, as a member. This committee meets twice a year, usually at Geneva, and its resolutions are presented to the Council of the League for approval. The members of the Health Committee are selected as health experts and not as delegates of their governments as in the case of the Office International d'Hygiene publique.

Permanent Secretariat

A body of permanent officials composes the general secretariat of the League, and insofar as the Health Section is concerned, the permanent secretariat consists of fifteen physicians of various nationalities and the necessary clerical staff.

PROCEEDINGS OF THE SIXTEENTH SESSION

The 16th session of the Health Committee was held in Geneva from September 29th to October 7th. This was the first session of the committee since it was reconstituted with the appointment of eight new members to replace those whose term of office of three years had expired. For the fourth time the committee elected Dr. Madsen, director of the Danish State Serum Institute, as president. Dr. Madsen has been president of the Health Committee since its foundation in 1923. It is of interest to note the truly international character of the Health Committee as evidenced by the following list of members:

Professor Ascoli, Professor of the Medical Clinic of Rome University; Prof. L. Bernard, Professor of Tuberculosis, Faculty of Medicine, Paris; Prof. Bordet (new member), Director of the Pasteur Institute for Brabant, Brussels; Sir George Buchanan, Senior Medical Officer of the British Ministry of Health; Dr. H. Carrière, Director of the Swiss Public Health Service; Professor C. Chagas, Director of the Oswaldo Cruz Institute at Rio de Janeiro; Dr. W. Chodzko, Director of the State School of Health, Warsaw; Surgeon-General H. S. Cumming, Director-General of the United States Public Health Service; Professor J. G. FitzGerald (new member), Director of the School of Hygiene and Connaught Laboratories, University of Toronto; Gen. J. D. Graham, Indian Medical Service; Prof. C. Hamel, President of the *Reichsgesundheitsamt*, Berlin; Prof. J. Jadassohn (new member), Director of the Dermatological Clinic of Breslau University; Dr. N. M. J. Jitta, former President of the Public Health Council of the Netherlands; Prof. Ricardo Jorge, Technical President of the *Conseil Supérieur d'Hygiène*, Lisbon; Dr. A. Lutrario, former Director General of Public Health, Ministry of Interior, Rome; Prof. G. Pittaluga, Director of the School of Hygiene, Madrid; Dr. L. Raynaud, Inspector General of the Health Service of Algeria; Professor J. Scoseria, President of the Uruguayan Health Council; Dr. A. Stampar (new member), Inspector General of Public Health at the Ministry of Social Welfare and Public Health, Belgrade; and Dr. M. Tsurumi, representative of the Central Sanitary Bureau, Ministry of the Interior, Tokyo.

In his report Dr. Madsen emphasized the importance of the international aspect of the work of the Health Organization of the League, and the essential similarity, in spite of wide local differences, of health problems in the different countries and different areas, whether rural or industrial. The work of the Health Organization falls into three stages,—the collection and study of information, forming general judgments on the basis of the data collected, and, finally, action. During the past ten years certain of the activities have become regarded as practically permanent by governments and scientific institutes. The work of the permanent Standardisation Commission in devising and maintaining uniform international standards pertaining to biological

products, the work of the Opium Commission, the Malaria Commission, and the Commission on Leprosy are examples. Other studies are necessarily of temporary character. There is need for analytical comparison of the pooled knowledge and experience of the leaders in public health and medical research in problems of maternal and infant welfare, rural health and the treatment of syphilis.

The International School of Advanced Health Studies

The French Government proposes to establish a school for advanced post-graduate study for public health officials. The school is to be maintained by an annual grant of a million French francs, and will be under the direction of a governing body composed of members of the Health Committee with a member of the committee of directors appointed by the French Government. It is expected that students will, generally, be selected by their national authorities, and that in due course various scholarships will become available for students.

European Conference on Rural Hygiene

At the suggestion of the Spanish Government with the approval of the Council, the European Conference on Rural Hygiene will be held at Geneva on April 23, 1931. The Conference is to be strictly technical in character, and will consist of technical delegates such as sanitary engineers, public health officers, representatives of farmers' associations, representatives of social insurance associations, etc.

Reports of Studies

An interesting account of the studies of the malaria commission in India was presented by Dr. Schuffner. Ninety per cent of the population of India are rural and the crux of the problem lies in meeting the situation in its 700,000 villages. The work of the commission on leprosy is being rapidly extended and a report of a survey in Europe, America and the Far East was presented by Dr. Burnet, secretary of the commission.

Progress in the plans for the health reconstruction in China was reported, indicating that joint action by Chinese and the foreign municipal authorities in Shanghai has been successfully undertaken. The establishment of the central field station for health work at Nanking was outlined. Co-operation with the government of Bolivia in the reorganization of its health service was presented in a report by Dr. Mackenzie. In order to compare the value of various methods employed in the sero-diagnosis of syphilis, an important serological conference is to be held in Montevideo. In addition to the European Conference on Rural Hygiene, a conference of Directors of Schools of Hygiene throughout the world will be held in Madrid next spring.

R. D. Defries, M.D., D.P.H.

Editorials

HEALTH INSURANCE

THERE are many reasons why public attention in this country tends to centre on health insurance at this time. The need for health insurance was seen in Europe as early as 1883 when Bismark introduced it in Germany. Since that time in one form or another it has been adopted in most of the countries of Europe and in other countries, while in some legislation is now pending. Throughout the British Dominions a health insurance policy has crystallized into definite legislation only in Great Britain, Northern Ireland and the Irish Free State. In Australia and New Zealand Royal Commissions now have the matter under consideration. This is also the case in two provinces of Canada, Alberta and British Columbia, while in Quebec a commission is considering the whole question of social insurance, including health insurance.

From the growing list of countries which have either adopted health insurance or are likely to adopt it soon one cannot but feel that the time is opportune in Canada for us to seriously study the whole question with a view to being ready to organize and plan wisely prior to legislative action.

There has been sporadic opposition to the introduction of health insurance in different countries—particularly by medical groups. This opposition has usually arisen because of the actual existence or the possibility of certain abuses, or apprehension lest the introduction of the unique principles involved may seriously interfere with the status and efficiency of medical practice. While these fears are not entirely groundless if proper precautions are not taken, yet the reasons for instituting some form of health insurance are sound, so sound indeed that it is only a matter of time till public opinion demands action.

A canvass of the situation leads one to believe that in so far as employers, the employed and the state are concerned, all three are likely to gain through the creation of any machinery which mitigates the serious results of uncared-for illness. The present hit-and-miss method whereby medical care may be denied to large groups of responsible people, whereby it would almost seem that every possible deterrent is present to prevent many from obtaining medical attention as soon as it should be given, is not satisfactory. Where prompt medical attention is not readily available it frequently means prolonged illness or indeed death—and the value of health is very evident to the employer when the lack of it means time lost, decreased output and

lower profits. Many industrial concerns have already demonstrated their interest by providing medical care for their employees. The interest of the employed person is sufficiently obvious. Every wage-earner knows that it does not pay to be ill. He also realizes that in spite of his efforts to help himself through the medium of sick benefit societies, friendly societies, and the like, no voluntary unsubsidized method has yet been evolved which is stable and effective.

In the case of the state both duty and interest are evident. There are many practical reasons for the discussion of health insurance. The serious feature of the present situation is that many persons fail to receive medical care when they need it—that illness is too prevalent and that death frequently comes too soon. Other compelling reasons are seen in the fact that under present conditions physicians are too frequently either unpaid or underpaid—and that a large proportion of persons either fail to pay their hospital bills or pay them only in part.

A recent statement by Dr. Alfred Cox, Medical Secretary of the British Medical Association, would indicate that on the whole the British medical profession is fairly well satisfied with the National Health Insurance Act. In Canada the medical profession is alive to the situation and as the public demand increases will be ready unquestionably to call attention to certain essentials in sound health insurance legislation which have been neglected in many of the existing schemes. It is well that the medical profession is not unaware of the dangers which are involved in delaying careful study of the question, until it is too late, to provide essential safeguards. They will insist, too, we believe, on adequate attention to the advances which have been made in preventive medicine since the introduction of earlier schemes. The prevention of unnecessary illness and death should be the keynote of all such legislation.

Many
Merry Christmases
Many
Happy New Years
Unbroken Friendships
Great Accumulation of Cheerful Recollections
Affection on Earth, and
Heaven at last for all of Us.

CHARLES DICKENS.

CHILD HYGIENE

J. T. PHAIR, M.B., D.P.H. AND H. E. YOUNG, M.D., LL.D.

SOME OBSERVATIONS ON THE DIET OF CHILDREN OF SCHOOL AGE

J. T. PHAIR, M.B., D.P.H.

MUCH has been said during the last few years as to the merits and demerits of certain feeding practices, of certain articles of food commonly consumed by children; of the necessity for including in the diet of individuals of all ages, and particularly young children, certain types of food presumed to be fundamental to satisfactory growth and development. Much of the information given out, through both lay and professional channels, has been founded on fact and endorsed by those best qualified to express an opinion on such a subject; much of it has been misinformation, either wilfully disseminated by persons for gain or unwittingly distributed by those to whom the public, apparently of necessity, turn for guidance on such matters; namely, the daily and journalistic press. The fact remains that a lot of advice has gone forth apparently basicaly sound and presumably practicable of easy adoption by all classes. One wonders to what extent this advice is adopted by the children of school age, and to what extent its non-adoption is due to the lack of conviction of its desirability by the child or of its essentialness by the parent or parents concerned.

An opportunity recently presented for an enquiry among the school children in a city in Ontario, wide-awake to both its educational and health needs, as to the extent to

which the health information, directed at them from all angles, was being practised. The number reached by the survey was about four thousand. For the purpose of this article, only those in the Junior Second and Senior Fourth are dealt with, however. An effort was also made to note conditions in terms of the economic status of the parents.

Senior Grades

Among all the boys in the Senior Fourth grade, 28 per cent of them had a hot cereal for breakfast; 36 per cent had a cold cereal; 30 per cent had raw or cooked fruit, and 23 per cent had egg or bacon; 31 per cent had tea or coffee; while almost 60 per cent had milk or cocoa. Only 2 per cent included in their breakfast such undesirable food as pie, cake, sausage, doughnuts, pancakes, etc. None came to school without breakfast although a small group had toast and tea only.

Luncheon could be described as adequate in only 18 per cent of cases; as fair in 50 per cent and poor in 32 per cent.

Tea and coffee was admittedly consumed by 57 per cent, while 26 per cent did not drink milk at all and 26 per cent took only one glass.

As regards the relationship between those children coming from the better homes and those from the poorer—breakfast was a very comparable meal apparently in both types of

home, except that tea and coffee were found more commonly in the poorer; but luncheon was found to be adequate in only 8 per cent of the poor homes and poor in 52 per cent, while in the better class homes the ratio was 25 per cent and 20 per cent.

Among the girls in the senior grade was found a larger measure of deviation from a desirable normal than was found among boys of the same age. In the best section of the city, several of the older girls were in the habit of foregoing breakfast; 25 per cent consumed articles described as undesirable. Tea or coffee, however, was not as commonly taken as among the boys. The lunch eaten was apparently better than that eaten by the boys, only 9 per cent being classed as poor and 51 per cent adequate.

Among the girls in the poorer section of the city, the number taking hot cereal was much lower than in the previously mentioned group, while tea or coffee was more frequently taken for both breakfast and lunch. The percentage of those eating foods classed as undesirable was about 33 per cent. All, however, had had some breakfast. The number eating a satisfactory lunch, namely, 33 per cent, was much lower than in group number one. Fifty-five per cent took what was described as a fair lunch. Among this grade throughout the entire city, only 25 per cent of the girls took a hot cereal; 50 per cent ate some fruit; 25 per cent egg or bacon, and almost 40 per cent ate some type of so-called undesirable article of food for breakfast. Milk, in some quantity, was taken by about 80 per cent of these girls. Luncheon was found to be adequate in 45 per cent; fair in 42 per cent and poor in 13 per cent.

Junior Grades

In the junior grades among boys in the better class district, hot cereal and fruit were taken in better than 50 per cent of cases; tea or coffee was taken by 30 per cent. Luncheon was found to be more unsatisfactory than among the senior pupils; 45 per cent being poor. In the poorer section, these children were found to have little fruit, egg or bacon; hot and cold cereals were evenly divided; milk or cocoa was drunk by about 50 per cent for breakfast. The lunch given these children was poor in 45 per cent of cases and adequate only in about 5 per cent.

The girls in the junior grades were found, in the best section of the city, to have for breakfast hot cereal in 25 per cent of cases; cold cereal in 32 per cent; fruit, 50 per cent; eggs or bacon in 10 per cent; undesirable articles were taken in 25 per cent; milk or cocoa in 70 per cent. Lunch was adequate in 20 per cent; fair in 75 per cent and poor in 5 per cent of instances. All of the children drank some milk during the day.

Among those resident in the poorer section, hot cereal was eaten in 32 per cent of cases; cold cereal in 25 per cent; fruit in 14 per cent; egg or bacon in 5 per cent; milk or cocoa was taken in 60 per cent and undesirable articles in 30 per cent of cases. Lunch was adequate in 36 per cent; fair in 18 per cent and poor in 36 per cent. Milk was taken by all of the children in this group.

Throughout the city, the junior girls were noted to be evenly divided as to the merits of hot and cold cereal. Only 55 per cent, however, ate cereal of either type; 23 per cent took fruit; 19 per cent egg or bacon; 14 per cent

tea or coffee; 70 per cent milk or cocoa; 15 per cent had undesirable types of food. Lunch was said to be satisfactory in 27 per cent of cases, fair in 52 per cent and poor in 23 per cent. Twenty-two per cent had no milk at all during the day, and 27 per cent took tea or coffee.

One is frankly hesitant about drawing any inferences from such data as were obtained. The subject, however, warrants further study, and every opportunity which is presented to measure the relationship between health teaching and health practice should be taken advantage of.

PUBLIC HEALTH NURSING

RUBY M. SIMPSON, Reg.N., and FLORENCE H. M. EMORY, Reg.N.

THE VICTORIAN ORDER OF NURSES IN THE MARITIMES

WINNIFRED DAWSON, REG. N.

Though branches of the Order are to be found in every section of Canada from Victoria, B.C. to Sydney, N.S., there is possibly no more interesting group of centres than those in the Maritimes, both from the standpoint of location and that of variety of service carried. In centres of three thousand population or less, usually only one nurse is employed and, as the Order is the only agency carrying a public health nursing service in these particular centres, the scope of the health work is limited only by her time and energy.

In Digby, that picturesque little town nestled in the hills, overlooking the blue waters of Digby Basin, the nurse, a graduate in public health nursing, gives bedside care including confinement service (always, of course, under doctor's orders), health teaching in the home, holds weekly conferences for mothers and babies, visits the school, teaches Little Mother League classes weekly and makes instructional home visits to antenatal and postnatal cases, to infants, pre-school and school chil-

dren. The work done in Digby is but a sample of what is carried on in other centres.

In quaint old Pictou, the nurse is welcomed wherever her work takes her and thus a wonderful opportunity is afforded for health teaching. It is the same in the other "one nurse" centres, Fredericton, Sackville, Marysville, Wolfville, Kentville, Lunenburg and Canso.

Canso, situated on a rocky promontory on the strait of the same name, is peculiarly isolated. As there is no hospital, the service of the Victorian Order nurse is especially welcome. One of the local doctors examines the school children yearly without remuneration and the nurse does the follow-up work and health teaching. In Marysville, industrial nursing in connection with the factory of Canadian Cottons Limited, is also undertaken.

In the larger centres where two or three nurses are employed, as in Moncton, Yarmouth, Dartmouth, New Glasgow and Truro, the nurses and the local committees meet the

added responsibilities as they arise, with courage and understanding, striving to maintain the standards of modern public health nursing. The municipalities, too, in most instances assist with a liberal grant.

In historic Halifax, the Order has carried on for over thirty years, growing with the city, organizing services as they were required, and later relinquishing certain activities to the official agencies when they desired to carry these obligations, until at present, with the efficient Health Centre functioning, the Victorian Order service consists of bedside nursing and health teaching in the home, attendance at, and follow-up work from, the antenatal clinic and responsibility for the North End Health Centre, as well as the usual class work with Little Mothers.

Likewise, in the ancient city of St. John, the nursing service is maintained by a staff of eight. St. John has long been the rendezvous for sailors from all parts of the globe, giving, it is true, certain picturesqueness, but nevertheless adding to the problems of sociology and public health. A spacious building now houses the agencies engaged in public health work and following the policy of the Victorian Order, the nurses in that branch are to be found supplementing the work of the official agencies and co-operating in every way

possible. The service is a pre-natal and maternity one with its affiliated teaching, the babies being transferred to the care of the child welfare nurses after two weeks.

Sydney, too, with its busy steel plant, has a group of Victorian Order nurses engaged in all forms of public health nursing except that of school work. Nearby, in the heart of the coal fields, at Glace Bay, a new branch of the Order has recently been organized. Here, a group of public-spirited citizens are making a determined effort to cover the health needs of the miner and his family. With the assistance and co-operation of the members of the two hospital boards, medical social service is to be added to the usual programme of activities and it is hoped that the service as planned will prove adequate to the needs of the community.

In a voluntary organization such as the Victorian Order of Nurses for Canada, the attitude of the people towards the problem of public health may be gauged, and, judging from the continued support which the local branches of the Order have received through the period of changing values experienced in recent years and the liberal attitude taken by the committees towards the ever enlarging scope of the work undertaken, the future of public health nursing in the Maritimes augurs well.

CORRESPONDENCE

Immunization Against Diphtheria

To the Editor:

I am very interested in toxoid immunization. Last year I immunized about 800 children against scarlet

fever, and I am now immunizing a larger number against diphtheria.

I read in the *Canadian Public Health Journal* that the campaign in Manitoba has been made possible by the assumption of the financial obligation

by the individual municipalities through an increase in taxes, etc.

I would be glad to know, which cities did this and how much the tax-rate was raised.

Thanking you in anticipation,

Yours very truly,

G. A. Ootmar,
Medical Health Officer,
Kelowna and District.

Dr. Ootmar's letter was sent to Dr. F. W. Jackson, Deputy Minister of Health and Public Welfare, Manitoba, who kindly replied as follows:

Dear Doctor Ootmar:

In regard to this programme in Manitoba, during the past year an effort has been made by this Department to interest municipalities outside of Winnipeg in immunizing their children. This has been done by means of circular letters to and interviews with the municipal councils, as well as articles in the daily papers regarding the diphtheria situation.

The plan worked out for the actual programme is that the municipality instructs their health office to give the immunization to all the children in the municipality between the ages of one and fifteen. The Department supplies toxoid free of cost, as well as form letters with literature regarding diphtheria and toxoid administration for

the parents. The form letter contains a proviso whereby if they do not wish their children immunized the parents can return the letter to the school with their signature, and their child, or children, will be left out when the work is commenced.

The health officers make their own arrangements with the municipalities as to their remuneration, and this money is charged back to the people in the ordinary taxation.

All the work is done through the schools and the parents are asked to bring the children of pre-school age to the schools on the dates set. We have tried to supply a public health nurse to every municipality putting on this programme. The nurse helps the local physician, and in this way we have pretty well standardized the method of immunization.

This year we will have immunized approximately 30,000 children outside the City of Winnipeg.

We find by a municipal programme that approximately 90 per cent of the children are immunized, whereas, if it is left to the individual parents to have the work done, we do not get more than from 40 to 45 per cent.

Trusting this is the information you desire, I beg to remain,

Yours very truly,

F. W. Jackson, M.D., D.P.H.

REPORTED CASES OF CERTAIN COMMUNICABLE DISEASES IN CANADA* BY PROVINCES—OCTOBER, 1930

Diseases	P.E.I.	Nova Scotia	New Brunswick	Quebec	Ontario	Mani- toba	Saskat- chewan	Alberta	British Columbia
Diphtheria...	3	40	26	212	373	35	35	26	32
Scarlet Fever..	3	98	80	411	435	78	32	40	75
Measles.....	—	4	1	167	57	18	16	1	43
Whooping Cough.....	—	13	—	234	315	61	33	18	171
German Measles....	—	—	—	9	7	†	1	1	3
Mumps.....	—	12	—	85	152	62	5	6	20
Smallpox.....	—	1	—	6	34	—	3	22	1
Cerebrospinal Meningitis..	—	—	—	4	7	3	—	2	5
Anterior Poliomyelitis	1	17	—	7	174	13	19	24	13
Typhoid Fever	2	7	24	175	126	26	21	14	46

*Data furnished by the Dominion Bureau of Statistics, Ottawa.

†Not reportable.

NATIONAL VOLUNTARY HEALTH AGENCIES

RUBY E. HAMILTON, Reg.N.

CANADIAN SOCIAL HYGIENE EXHIBIT
CANADIAN NATIONAL EXHIBITION, TORONTO.

THE Canadian Social Hygiene Council maintained two booths at the Canadian National Exhibition this year, one in conjunction with the Provincial Government of Ontario and the other with the National Council of Women.

of life's span were shown upon a painted background.

The booth in the Women's Building represented the family and indicated the value of social hygiene in keeping the family healthy and intact. At both booths a pamphlet dealing with



ONE OF THE TWO EXHIBITS OF THE CANADIAN SOCIAL HYGIENE COUNCIL, AT THE CANADIAN NATIONAL EXHIBITION, TORONTO, AUG. 22ND TO SEPT. 6TH, 1930

Periodic Health Examination was the subject stressed in the Government Building. The booth graphically represented the three score years and ten of human life by means of a swinging pendulum and a chain whose links were menaced by different diseases which might be detected in incipency and corrected through periodic health examination. The various causes of death and the most common disease of different periods

periodic health examination was distributed. This pamphlet, bearing a cartoon showing how periodic health examination assists in keeping death away from the home, stresses the co-operation of the Canadian Medical Association, the Federal Government and the life insurance companies in furthering this health protection measure.

Children were not forgotten. Card-board discs, bearing the printed sug-

gestion that the family doctor can keep children from getting sick and that mother should be asked about this, were given to them. In the centre of these discs two holes were punched and a double string run through so that the whole made a simple toy, the

child placing his hands through each end of the doubled string, winding it up and making the disc whirl back and forth just as children are accustomed to do with a large button and a string. These were extremely popular with the children.

NEWS AND COMMENTS

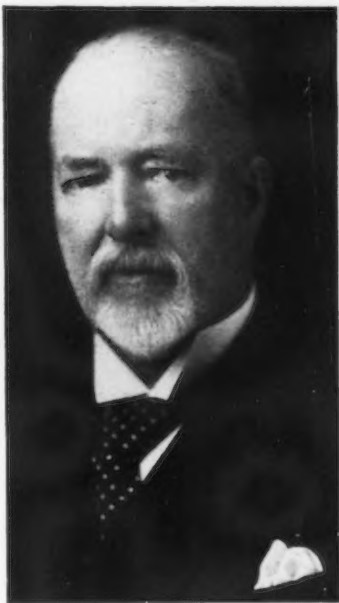
P. A. T. SNEATH, M.D., D.P.H.

Retirement of F. T. Underhill, M.D., F.R.C.S., D.P.H. Medical Officer of Health of Vancouver

AFTER thirty-two years of service as the Medical Officer of Health of Vancouver, Dr. Underhill tendered his resignation a few months ago. The health department which he created is now outstanding on this continent. Great must be the satisfaction of any man in such an accomplishment, and great must be the pleasure of having the opportunity of watching its further developments while relieved of the arduous responsibilities of administration, and to be able now to enjoy to the full many of the interests for which time could not be spared in the responsibilities of his office. He has been the Dean of the health officers of our Canadian cities, and to few others has been given the

privilege of laying the very foundations of a city department of health, guiding its progress and, later, enjoying to the full the fruits of his labours.

Dr. Underhill was born at Tiptenden, Staffordshire, England, 1860. His father, grandfather and great-grandfather were physicians, and six of his brothers are physicians. Truly a family of physicians! His academic training was most complete for his work as health administrator. He is a Fellow of the Royal College of Surgeons, Edinburgh, and a Fellow of the Royal Sanitary Institute of England. In 1894 he came to Canada and



F. T. Underhill, M.D., F.R.C.S., D.P.H.
Retiring Medical Officer of Health,
Vancouver, B.C.

settled in Mission, B.C., and later made his home at Caribou, but seeing the need for public health work he re-

turned to Scotland, receiving his Diploma in Public Health after extensive post-graduate studies. On his return to Canada, he became part-time Health Officer in Vancouver. So successful was his work in developing the Department, that he was requested to give his entire time to these duties. Thus in 1904 Vancouver had the distinction of being one of the few cities in Canada with a full-time medical officer of health. With the rapid growth of the city, Dr. Underhill's department kept pace with the needs. Provision for all time of an absolutely pure, mountain water-supply from Capilano and the complete organization for the control of public milk supplies were accomplished; these will remain as an enduring tribute to his ability as a guardian of public health. His retirement has given opportunity to the medical profession of Vancouver and to his host of friends in Vancouver and throughout the Province to give expression to their admiration of his work and appreciation of his sterling character.

**Appointment of Dr. J. W. McIntosh, B.A., M.B., D.P.H. (Tor.)
Medical Officer of Health,
Vancouver**

THE city of Vancouver is to be congratulated on the appointment of Dr. J. W. McIntosh to succeed Dr. F. T. Underhill whose resignation after thirty-two years of notable service was tendered in September. Dr. McIntosh is eminently qualified for this important position. To a broad experience in medical practice, both as a practitioner and as a specialist, he has added an extensive knowledge of

public health administration. His academic training specially equipped him for his task. He is a graduate in Arts and Medicine and holds the Diploma in Public Health from the University of Toronto. He served overseas during the Great War, returning with a zeal to serve in every way in the rehabilitation of our ex-soldiers. He is known as an outstanding student of the fundamental problems of public health, drawing frequent attention in published articles to the problems of cancer, tuberculosis and the need for more adequate medical services.

The Association extends to Dr. McIntosh their heartiest wishes for every success in assuming his new office.

British Columbia

IN the November issue, in noting the appointment of Dr. A. K. Haywood as medical superintendent of the Vancouver General Hospital, his name was incorrectly given as Dr. C. Hayward. We regret greatly this error.

Manitoba

THE Honourable Dr. E. W. Montgomery, Minister of Health and Public Welfare, on behalf of the staff of the Department, presented Dr. T. A. Pincock with a silver tea and coffee service on the occasion of his retirement from the office of Deputy Minister. The Minister expressed his regret at losing Dr. Pincock, and extended to him the best wishes for success in his important appointment at the Brandon Mental Hospital.

The trachoma survey covering certain sections of the Province during the past summer was accompanied by a house to house canvass made by public health nurses who had received some special training in the ophthal-

mological departments of the city hospitals. In all, some 10,000 individuals were included in this survey of whom it was found that more than ten per cent exhibited conditions which might be considered as suspicious of trachoma. Arrangements are now under way to hold within the month clinics at eleven different points in four municipalities, under the direction of a qualified oculist, with the co-operation of the local physicians. One or two nurses will be engaged in the "follow-up" work to ensure the continuance of treatment by those affected with trachoma. They will be engaged also in an educational effort in the schools designed to make the population conscious of the seriousness of trachoma and to assure as far as possible treatment and prevention.

Miss K. W. Ellis has been appointed Superintendent of Nurses and Principal of the School of Nursing at the Winnipeg General Hospital. As Superintendent of Nurses in the Vancouver General Hospital for eight years, Miss Ellis is well known in hospital circles.

Ontario

A MENTAL health clinic has been inaugurated in Brantford as part of the provincial scheme, which provides for the organization of such clinics in important centres. In charge of the clinic are Dr. Finlayson, Mr. Goldhammer, psychologist, and Miss L. Oliver, Social Investigator. The clinic will be held twice monthly.

Dr. Edward Ryan, Superintendent of the Rockwood Hospital for the past twenty-five years, has resigned his appointment. Dr. Ryan has been closely associated with medical circles in Kingston and has made a signal contribution to hospital practice.

Dr. T. D. Cumberland has been appointed superintendent of the Ontario Hospital at Kingston. Dr. Cumberland graduated at the University of

Toronto in 1913 and received an appointment at the Ontario Hospital, Toronto. He has served as assistant superintendent at the Ontario Hospitals at Whitby, Kingston, Brockville and Woodstock.

Dr. C. M. Hincks who is medical director of the Canadian Committee for Mental Hygiene has been appointed general director of the parent body in the United States succeeding Dr. Frankwood E. Williams who is retiring on January 1st, 1931. Dr. Hincks will remain in Toronto and in addition to his new appointment will retain his post in the Canadian organization.

A serious outbreak of septic sore throat is reported from Kirkland Lake. Immediate steps have been taken by the Department of Health, Ontario, to control the epidemic and to provide necessary relief measures. At this time it is not possible to state the number of cases, but a very considerable proportion of the population have suffered from the disease.

Quebec

AT the recent biennial congress of the Association of French-speaking Physicians of North America held in Montreal, a decision was made to hold the next meeting in Ottawa in 1932. This will be the first occasion since the Association was organized thirty years ago that its meetings will be held outside of the province of Quebec. The recently elected officers are: Dr. R. E. Valin, Ottawa, President; Dr. Albert Paquet, Quebec City, Dr. J. R. Deslise, Hull, and Dr. A. Panger, Tulane University, New Orleans, Vice-Presidents; Dr. Domilien Marion, Montreal, Recording Secretary; Dr. J. H. Lapoint, Ottawa, Secretary of the congress; and Dr. Eugene Caulin, Ottawa, Treasurer.

The Cook Hospital, Three Rivers, has been opened and constitutes one of the finest institutions for the treatment of tuberculosis on the continent.

In the presence of a large gathering the new Mt. Sinai Sanatorium, Ste. Agathe, was opened and dedicated on October 5th. The building is beautifully situated and is a modern four-story building fitted with the latest devices for sanatorium equipment.

Dr. A. Grant Fleming, D.P.H., Professor of Public Health and Preventive Medicine, McGill University, has arranged to assist in the work of the Canadian National Committee for Mental Hygiene making it possible for Dr. C. M. Hincks, Medical Director, to assume the direction of the work of the National Committee for Mental Hygiene in the United States.

New Brunswick

THE new wing to the Moncton City Hospital was officially opened October 28th last with A. C. Chapman, Chairman of the Moncton Hospital Board, presiding. The speakers included His Honour, the Lieutenant-Governor, the Premier of the Province, The Hon. Dr. H. I. Taylor, Dr. C. B. Price, Senator C. W. Robinson, Mayor C. W. Redmond, Rev. Canon W. B. Sisain and W. W. Kenney, Esq., Superintendent of the Victoria General Hospital, Halifax, N.S. The new wing, which is a fireproof structure of three floors, provides accommodation for 74 additional beds, staff and administrative offices, admitting department, X-ray and laboratory branches and special kitchen equipment designed for the special instructions of student nurses in dietetics as well as special dining room accommodation.

The new Sunny View Hospital has been completed at Sackville, N.B. It represents the best in design and equipment for the small community hospital.

Nova Scotia

THE following are the officers of the Medical Health Officers'

Association of the Province of Nova Scotia: President, Dr. W. F. MacKinnon, Antigonish; Vice-Presidents, Dr. T. R. Johnson, Great Village, Dr. M. J. Wardrope, Springhill; Council Members, Dr. A. C. Guthro, Little Bras d'Or, Dr. A. E. Blackett, New Glasgow, Dr. F. E. Rice, Sandy Cove.

At the Exhibition in Sydney, Nova Scotia, The Provincial Department of Health had an excellent exhibit, and in the recent issue of the Nova Scotia Medical Bulletin a high compliment was paid to Miss Margaret Mackenzie for her presentation of the needs of infant and maternal care.

The opening meeting of the Halifax branch of the Medical Society of Nova Scotia was held at the Lord Nelson Hotel on Wednesday, October 15th, 1930, at 8 p.m. A very excellent programme for the coming season was announced. Fortnightly meetings are planned with alternate clinic meetings in the Victoria General Hospital, Nova Scotia Hospital, Children's Hospital and Gray's Maternity Hospital. On November 26th Professors Young and Dreyer of Dalhousie University presented the subject "Recent Advancements in Biochemistry and Pharmacology of the Internal Secretions." Other subjects to be presented at subsequent meetings are "Some Problems of Practice" by Dr. A. Calder, Glace Bay; "Some Phases of Metabolism", Dr. Harry O'Brien and Dr. Clyde Holland of Halifax. An afternoon will be spent at the pathological laboratory. The President of the Halifax branch is Dr. W. L. Muir.

Prince Edward Island

MORE than \$185,000.00 was raised by the campaign for the new Prince Edward Island Hospital, from October 1st to November 4th. It is expected that the construction of this new hospital will commence in the spring of 1931.

BOOK REVIEWS

D. T. FRASER, B.A., M.B., D.P.H.; R. R. McCLENAHAN, B.A., M.B., D.P.H.

Medical Insurance Practice. By R. W. Harris, Late and Assistant Secretary in the Ministry of Health, and Leonard Shoetin Sack, of the Middle Temple, Barrister-at-Law. Issued by the British Medical Association, Butler, and Tanner Ltd., Frome and London. pp. 368.

This small compact volume is a work of reference to the medical benefit provisions of the National Health Insurance Acts and was prepared, primarily, for the busy general practitioner. Its purpose is to answer every question which may arise in the physician's daily insurance work. Prepared in 1922, a second edition, embodying revisions of the Regulations of Medical Benefit appeared in 1924, and in 1929, a third edition was issued. What better tribute to its value can there be than that the third edition has been published by the British Medical Association! It is the standard work of reference for physicians and administrators concerned with the working of Medical Benefit. Within the compass of 368 small-sized pages and twenty chapters is presented every aspect of the subject including such topics as the relationship of the physician to the authorities and to insured persons, the nature of the medical treatment and attendance, prescribing and supplying drugs and appliances, issuing of certificates of incapacity, records of illness, remuneration, etc., etc. The third edition is published in a very attractive form and at a minimum price. It will meet fully the who desire the details of the practical operation of the scheme in England.

R.D.D.

Hygiene—By J. R. Currie, Professor of Public Health, University of Glasgow. E. & S. Livingstone, Edinburgh. Canadian Agents, Macmillan Co. of Canada Ltd., 70 Bond St., Toronto, Can. 1930. 844 pages with 110 illustrations. Price \$8.00.

The appearance of a new text book on hygiene is an event of importance. The book is encyclopædic. Not only are the various subjects of hygiene introduced and discussed but an epitome of laws and regulations governing these subjects is appended to each chapter. Approximately one-third of the text is devoted to subjects having to do essentially with environment. The chapter on infectious diseases comprises a discussion of infection, toxins and antigens, immunity, epidemiology, disease control, isolation and alphabetically arranged sections upon specific infections. This section forms slightly less than a sixth of the book. The section on helminths, insects and arachnida deals with some fifty species within a space of an equal number of pages excellently illustrated. The problems of maternal, school and industrial hygiene are briefly outlined. The section devoted to vital statistics leaves nothing to be desired.

The type and illustrations are excellent. The author is to be complimented upon his style which is always clear, lucid and succinct. The book should prove invaluable to those for whom it is written and should be available in all health departments as a reference on English practice.

D. T. F.

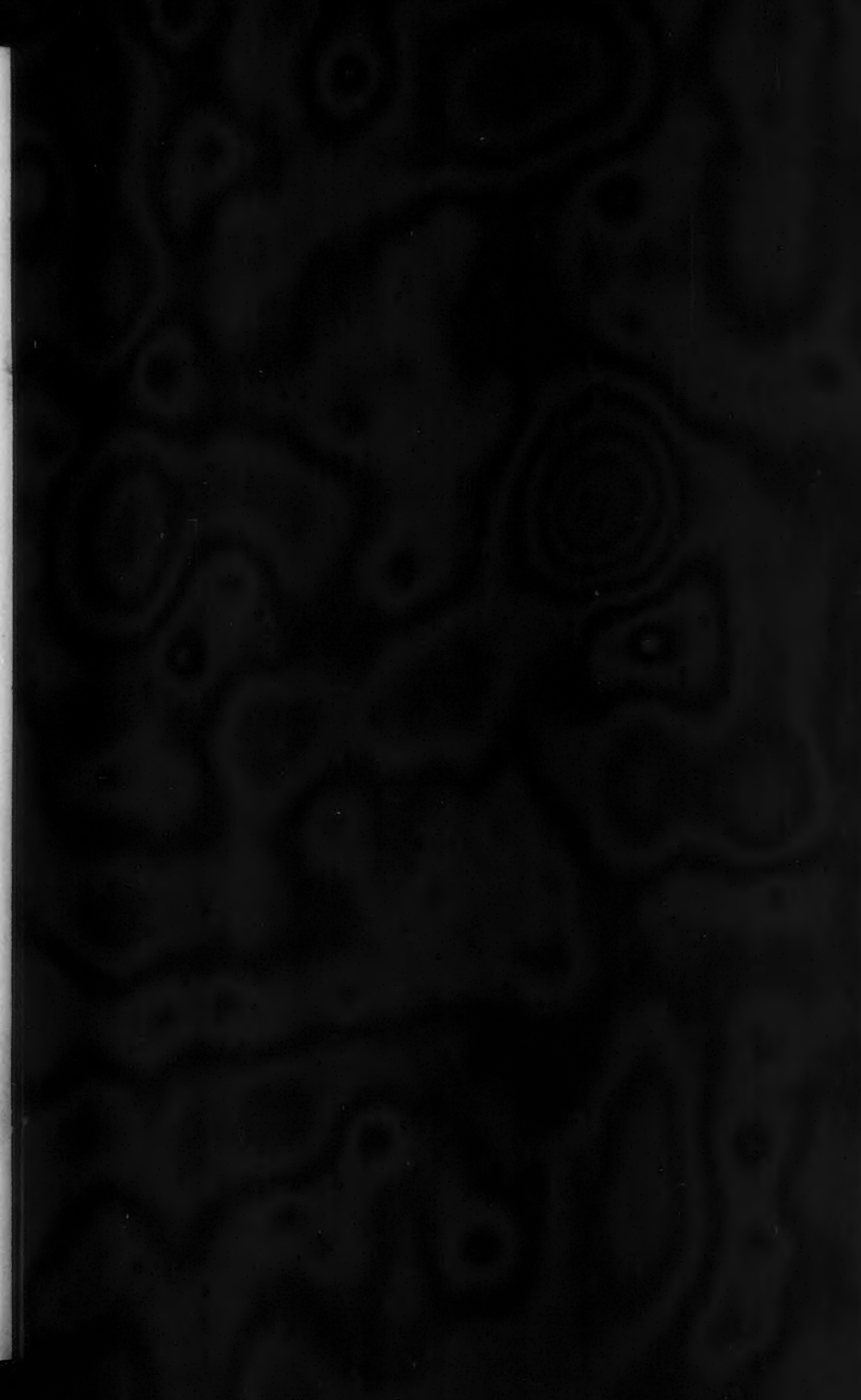
CURRENT HEALTH LITERATURE

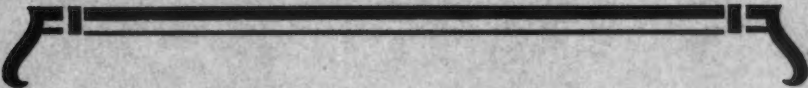
D. T. FRASER, B.A., M.B., D.P.H.

The Prevention of Tuberculosis Among Nurses. — Myers. *The American Jour. of Nursing*, Vol. XXX, No. 11, Nov., 1930.

The author states that,—“One of the greatest problems in the field of tuberculosis, at the present time, is the control of the disease among one of the most valuable groups of workers in the entire campaign—that of nurses.” The fact that the interval between exposure and the development of the disease in a clinical form is frequently long has been lost sight of by certain of those who have considered that the hazard of nurses in a sanatorium for tuberculosis is not great. The question is asked whether one is right in stating that practically no danger from exposure to tuberculosis in a sanatorium exists. Evidence is presented, based upon the results of investigations in Norway, Italy, Germany, Denmark, Canada and the United States, which would point to a higher incidence of tuberculosis among nurses. The fact that but a small percentage of physicians in a sanatorium or hospital break down with the disease while on duty does not reflect what will happen to them some years later. The author is firmly convinced that nursing is a far more hazardous occupation than it should be. The experience of Heimbeck in Norway is mentioned. He found that of 420 student nurses only 48 per cent reacted positively to the tuberculin test upon admission to the training school. When the negative reactors were, however, placed on a tuberculosis service practically all of them soon became positive to the

test. The evidence points to infection during their hospital residence. Whatever factors such as over-fatigue, loss of sleep and so on, may have to do with the development of clinical disease, Myers considers that,—“The greatest of all causes for the high incidence of tuberculosis among nurses is the exposure they suffer to the disease while in hospital or school residence.” There is no evidence to support the contention that the child is more susceptible to tuberculosis than the adult. The author expresses the conviction that not more than a fraction of what should be done to protect nurses against tuberculosis is actually being accomplished. He recommends the carrying out of an intracutaneous tuberculin test and X-ray examination of every applicant to a school of nursing. All positive reactors are to have an X-ray examination yearly or, better, every six months. The negatives are to have the test repeated every six months. All patients applying for admission to hospital should be examined for tuberculosis, including X-ray examination. The teaching and practice of the prevention of tuberculosis should be made an integral part of a nurse's examination so that the same technique as is employed in the prevention of spread of diphtheria is acquired. Very obviously periodic examinations at half-yearly or yearly intervals are a necessity, as well as a sympathetic and careful consideration of all illnesses of the nurse during her period of training. Such consideration is sometimes sparingly given by supervisors.







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